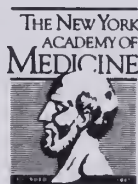




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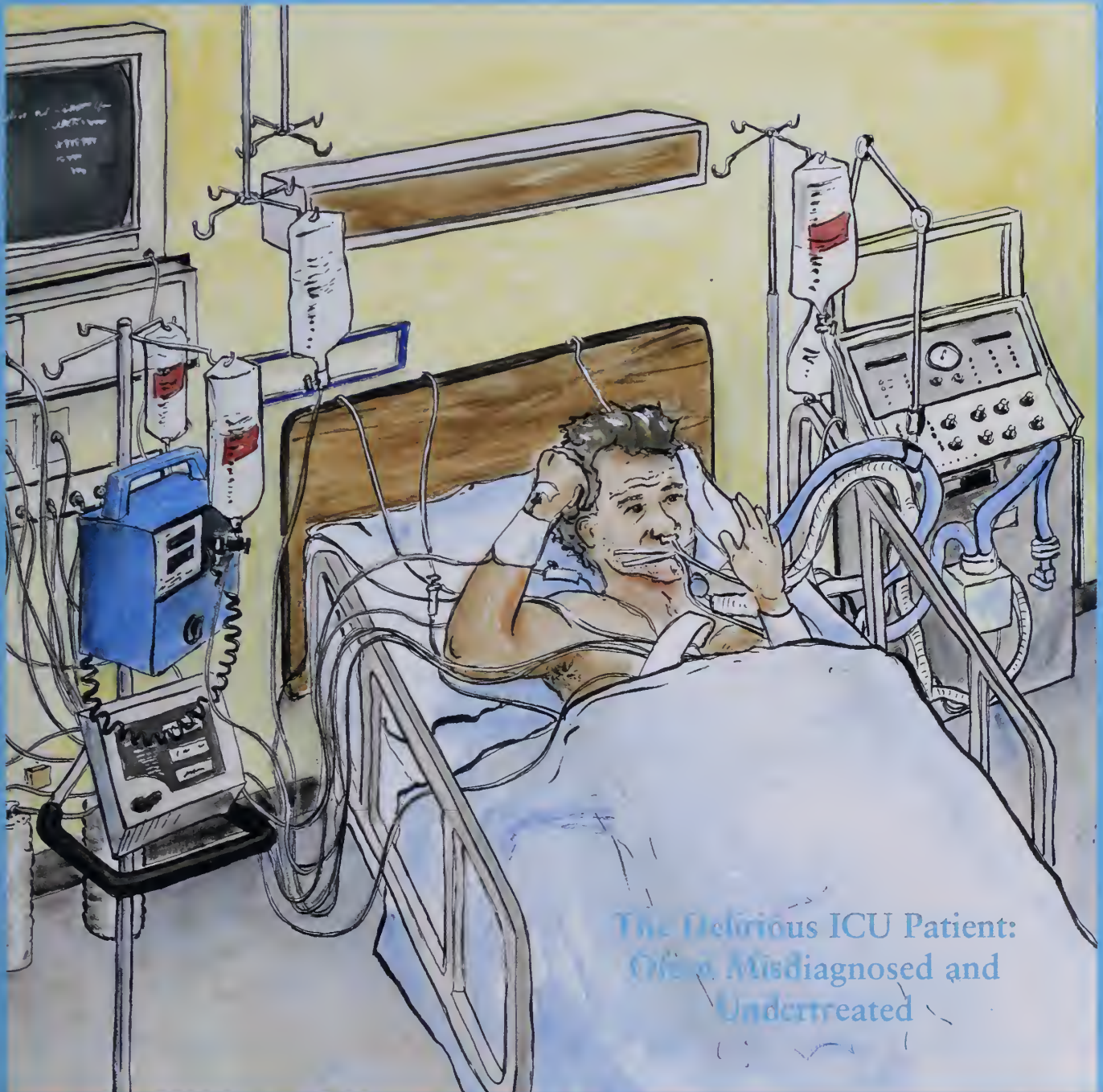
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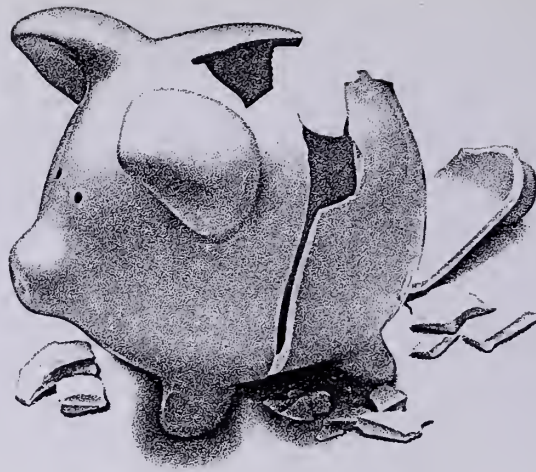
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The Delirious ICU Patient:  
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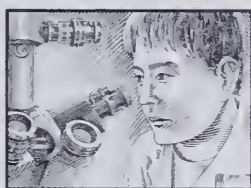


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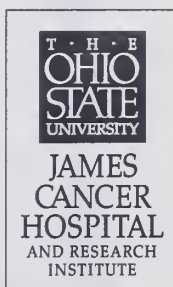


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**COVER:** Louisville surgeons discuss how to treat patients suffering from delirium in the ICU. See article on page 10. Cover art illustrates a delirious patient who is at risk of accidental extubation or loss of invasive monitors. Rapid sedation and control of symptoms may be necessary for his own protection. With permission to reprint from David A. Spain. Illustration and design by Lee Wade of Louisville.

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# Health Care Value: Cost Ratio

**W**hen we physicians hear, view, or read poorly researched *negative* reports about medical cost inflation, we *immediately* respond defensively. We feel guilty, hurt, and reluctant to discuss it. I would suggest that we take an *in-depth* look at this issue and study the *value: cost ratio* of medical care today as compared to the reference point of 1970 when medical costs were 7% of the GNP instead of today's 14%. I suspect every physician can look at the quality of care delivered in his/her specialty today and quickly decide that the *value* of care delivered has *grown* far more than have the costs. Somehow our critics would imply that the *quality* of health care hasn't changed, but the *costs* have become exorbitant. I *refuse* to accept that assertion. For example, since 1970 deaths from heart attacks, in this country, have dropped 40%. I am sure similar advances have occurred in all specialties. We are *clearly* able to do much more for our patients today than at any time in the history of medicine.

I doubt that any of us wish to return to 1970 *quality* of care, and I don't know of anyone in the United States who has sought health care in these other countries with reportedly *lower* health care costs. It's time for us to **praise** our health care in the United States rather than to apologize for it.

Let me review some reasons health care costs have risen:

- Aging of our population: Since 1970 life expectancy in the US has risen by an incredible 6 years. This has

happened despite, as Mike Royko wrote, "a nation of self indulgent, lard-buttied, TV gaping, couch potatoes." The fastest growing segment of our population is the over 75 years age group. The annual cost of providing health care to the under 25 year-old is \$900 compared to \$9000 per year in the over 75 age group. We don't need nor choose to apologize for increasing life expectancy.

- Technologic and pharmacologic advances: I am confident that 90% of the drugs I prescribe and

---

*"If we can help our critics and the public to focus on the value of the excellent medical results they are getting as much as on the dollars spent, I believe they will agree that the value: cost ratio has grown dramatically."*

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technology that I apply today were unavailable when I completed Cardiology Fellowship in 1970. Coronary angioplasty and other interventions have proven highly effective in improving quality of life as well as quantity of life. Thrombolytic drugs save hundreds of thousands of lives yearly in heart



Robert R. Goodin, MD

attack victims. Research is expensive, but none of us wish to see research and medical advances be stifled by economic restraints.

- Defensive medicine: The cost of liability insurance has *quadrupled* in only the past 15 years. Despite trial lawyers assertions to the contrary, the practice of defensive medicine is *very real*, and it is *expensive*. The best independent studies today report annual costs of defensive medicine to be \$25-35 *billion*. Effective tort reform could go a long way to significantly reduce health care costs.
- Unhealthy lifestyles: This may represent the area with the *most* potential for health care costs savings. The medically related annual costs of tobacco use, drug and alcohol abuse, teenage pregnancy, family violence, and lack of regular exercise is currently *265 billion dollars*. Consider that carefully — a full 26% of health care dollars spent in 1994 could be avoided or markedly reduced by healthy lifestyle habits. Compared to other developed countries, we in

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*"I doubt that any of us wish to return to 1970 quality of care, and I don't know of anyone in the United States who has sought health care in these other countries with reportedly lower health care costs."*

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the United States rank near the bottom of the healthy lifestyle scale. The public does have a responsibility to contribute to this rush to health care costs containment.

- **Consumer demands:** In the United States we have come to *expect* the very best educated physicians in the world, *access* to the very latest technology, and we want it in a very *timely* manner — like today or tomorrow. In Toronto, Canada, on the other hand, an *average* of 1000 patients are waiting for coronary bypass surgery on any given day. Their *wait* averages *6-8 months*, and the *mortality of waiting* is actually *higher* than the operative mortality. We neither *want nor deserve* that quality of "free health care and universal coverage" in the United States. Someone has correctly stated, "if you think health care is expensive now, just wait until it is free."

Despite these obvious reasons for health care cost escalation, we providers also have a role to play in cost containment. We *must* assume our appropriate responsibilities where possible. We clearly have too many hospital beds, too few primary care physicians, and too many specialists. Our medical schools and residency programs need to focus much more attention on *preventive* health care education and appropriate selection and use of expensive high technology. I believe we also have a major obligation to communicate better with our patients and families at the end of life. Thirty percent of the health care dollars are spent in the final year of life. Most of that is appropriate, of course, but as difficult as it is, we need to reduce non-beneficial care in futile situations, and instead focus more on comfort and compassion care. This should not be

done purely to save money, but because it is the right thing to do. Recently passed legislation in Kentucky should facilitate this approach.

There are economists and regulators in Frankfort and elsewhere who try to lay the responsibility for rising health care costs at the feet of physicians. Consider this however — physicians receive *19%* of the health care dollar (*12% of the Medicaid dollar*). That means that with above *50%* practice overhead, if physician reimbursements were *cut* by a full *50%*, the actual *reduction* in health

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*"... We providers also have a role to play in cost containment. We must assume our appropriate responsibilities where possible."*

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care costs would be only *4.5%*. I hope for the day when policy makers allow physicians to participate in the process of health system reform so that *effective* cost containment can be done *without* giving up quality care to our patients. If we can help our critics and the public to focus on the *value of the excellent medical results* they are getting as much as on the *dollars spent*, I believe they will agree that the *value: cost ratio* has grown *dramatically*. We physicians need to take an *offensive* rather than *defensive* posture in this debate.

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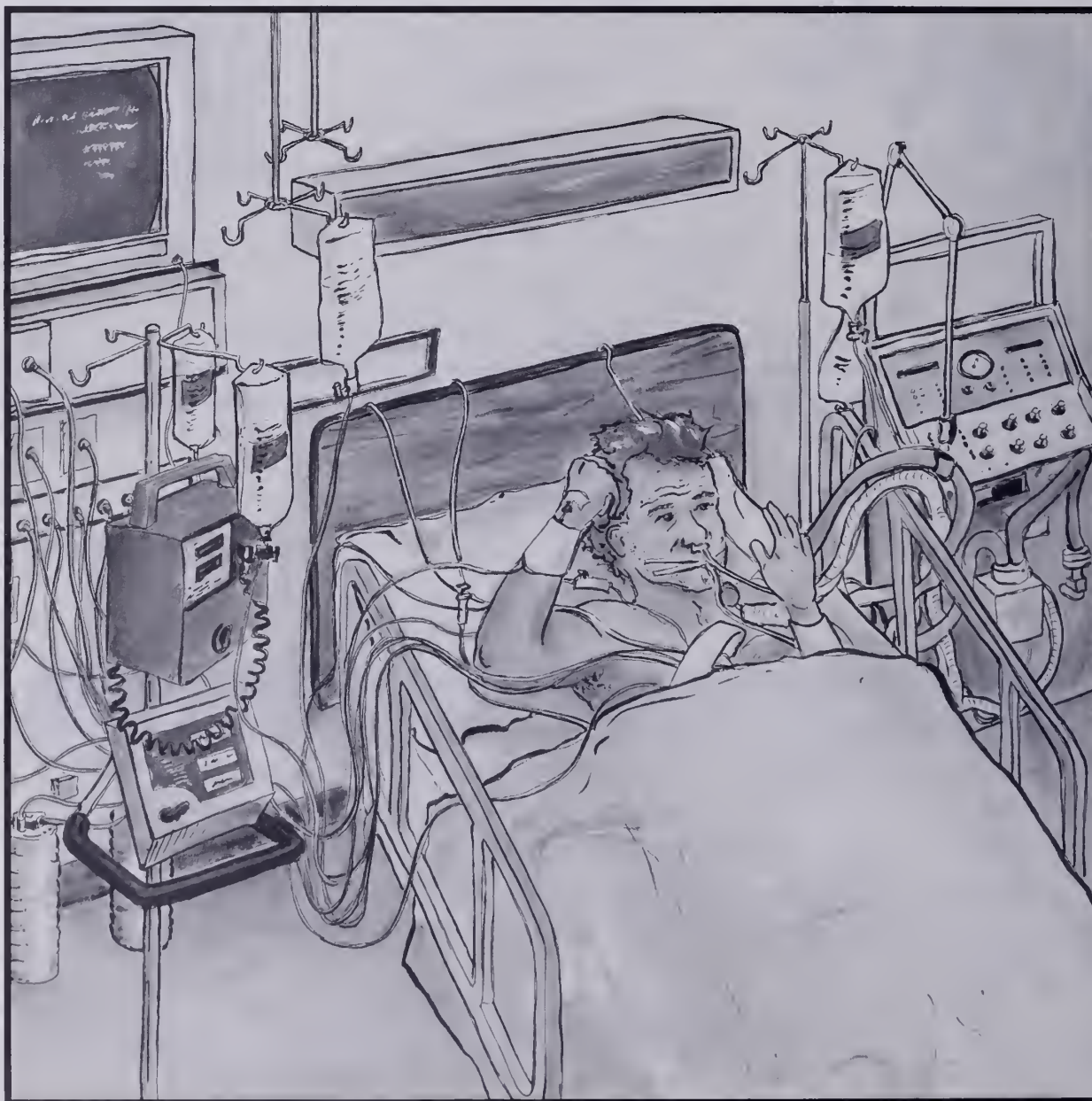
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# The Delirious ICU Patient: Often Misdiagnosed and Undertreated

*David A. Spain, MD; Frank B. Miller, MD*



**D**elirium is characterized as an acute, reversible mental disorder in which patients experience disorganized thinking and reduced ability to maintain attention on external stimuli. Delirium is also the most common psychiatric problem encountered in the hospital setting,<sup>1</sup> occurring in 5% to 30% of intensive care unit (ICU) admissions,<sup>2</sup> 10% to 40% of common surgical procedures,<sup>3,7</sup> and 10% to 50% of all elderly patients admitted to the hospital.<sup>8-10</sup> Despite this prevalence, it is often misdiagnosed as dementia or a functional psychiatric disorder. Lyness<sup>11</sup> corrects several misconceptions that are responsible for the often missed diagnosis of delirium (Table 1).

Prompt diagnosis with appropriate treatment is essential in the care of patients suffering from delirium, especially because of the increased morbidity, mortality, and hospital length of stay that is associated with it.<sup>1,5,8</sup> These increases may be primarily due to the underlying illness or condition that predisposed the patient to delirium. Generally viewed as a transient syndrome, the onset of delirium in the elderly patient may lead to persistent symptoms and require the patient to be placed in a nursing home.<sup>10</sup>

## Diagnosis

Global impairment of cognitive functions (ie, perception, thought processes, memory) is the clinical hallmark of delirium. Diagnostic criteria are based on the definition in the *Diagnostic and Statistical Manual of Mental Disorders* (Table 2).<sup>12</sup> The clinical presentation of delirium usually includes several lucid days in the hospital, followed by the sudden onset of incoherent, disordered speech, alternating agitation and lethargy, disturbances in the sleep-wake cycle, memory impairment, and occasional hallucinations. Patients are often suspicious, hostile, and combative. Therefore, those suffering from delirium are often misdiagnosed with "ICU psychosis," although actual psychosis in the ICU is uncommon.<sup>1</sup> Symptoms often worsen at night, giving rise to the term "sundowning." The reasons for "sundowning" are unclear but may be related to sleep deprivation, fewer nursing personnel, less patient stimulation at night, and more frequent use of restraints.

## Differential Diagnosis

Dementia and alcohol withdrawal are the two most common differential diagnoses for delirium. Both of these conditions may coexist in the pa-

**Table 1.** Correcting Common Misconceptions About Delirium

- Delirium does not always mean agitation.
- Patients may have lucid intervals.
- Patients may be depressed or irritable.
- Delirium is a common presentation of many medical illnesses.
- Delirium is not ruled out by the absence of obvious etiology.

tient with delirium, or may be risk factors associated with delirium, making the diagnosis very difficult.<sup>5,9,10,13</sup> Most patients with dementia have a history of cognitive impairment that declines within several months or years. The acute onset, fluctuating clinical features, and transient nature of delirium distinguishes it from dementia. Hallucinations, lucid intervals, and sleep disturbances are all common in delirium but rare with dementia.<sup>14</sup> Dementia and alcohol withdrawal may also coexist with delirium. In a large study of patients (aged 55 or older) admitted to a medical service, over 40% of those with dementia also exhibited symptoms of delirium.<sup>15</sup> The clinical presentation in this situation was usually one of long-standing mental status decline coinciding with an abrupt deterioration during acute physical illness.

Alcohol withdrawal, not delirium, is usually suspected in patients with a long history of alcohol abuse. Withdrawal symptoms typically begin 6 to 12 hours after admission to the hospital, which is much earlier than delirium. Initially, these patients have nausea and vomiting and are tremulous, anxious, and irritable. Autonomic hy-

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**Table 2.** Diagnostic Criteria for Delirium

- Reduced ability to maintain attention on external stimuli
- Disorganized thinking as evidenced by rambling, irrelevant, or incoherent speech
- At least two of the following:
  1. Reduced level of consciousness
  2. Perceptual disturbances
  3. Disturbance of sleep-wake cycle
  4. Increased or decreased psychomotor activity
  5. Disorientation to time, place, or person
  6. Memory impairment
- Clinical features develop over a short period of time and tend to fluctuate
- Either of the following:
  1. Evidence of a specific organic factor that is etiologically related
  2. Absence of nonorganic mental disorder accounting for the disturbance



## The Delirious ICU Patient

**Table 3.** ICU Drugs Associated with Delirium

Anticholinergics atropine antihistamines	Antihypertensives captopril methyldopa nitroprusside
Antibiotics amphotericin B cephalosporins ciprofloxacin metronidazole trimethoprim-sulfamethoxazole	Antiarrhythmics calcium channel blockers digoxin lidocaine procainamide propranolol quinidine
Narcotics	H <sub>2</sub> -blockers
Benzodiazepines	Steroids
Anticonvulsants	Theophylline

peractivity (ie, tachycardia, diaphoresis) is present and may help differentiate alcohol withdrawal from delirium. As withdrawal progresses (24 to 48 hours), patients become hyperexcitable, have insomnia, hallucinations, and may experience seizures. Ultimately, if undiagnosed or undertreated, this can lead to delirium tremens, which is characterized by agitation, hallucinations, and sympathetic hyperactivity.

### Etiology

The pathogenesis of delirium is unclear. The most widely investigated theory holds that reduction of cerebral oxidative metabolism and neurotransmitter imbalance leads to the development of delirium.<sup>16</sup> These alterations are thought to cause a deficit in the neurotransmitter acetylcholine, which is essential for normal cognition and maintenance of the sleep-wake cycle. This may explain the association between delirium and the use of drugs with anticholinergic properties. Additionally, many degenerative brain disorders, such as Alzheimer's disease, may involve a cholinergic deficiency, which may explain the increased susceptibility to delirium in patients with dementia. Lipowski<sup>16</sup> defined four major classes of organic factors involved in the development of delirium: (1) primary cerebral disease; (2) systemic illness or disease with secondary cerebral involvement; (3) exogenous agents, predominantly drug effects; and (4) drug or alcohol withdrawal.

By definition, most patients in the ICU will have systemic illness or diseases often complicated by sepsis and multiple organ dysfunction syndrome. Polypharmacy is common in the ICU

and may lead to adverse drug reactions or drug-drug interactions. Several medications have been implicated in the development of delirium (Table 3). The most common classes of drugs involved include anticholinergics, narcotics, antiarrhythmics, H<sub>2</sub>-blockers, and benzodiazepines. Although narcotics and benzodiazepines may cause delirium, withdrawal of these drugs, and alcohol as well, may lead to delirium and agitation.<sup>1</sup> Therefore, all patients with the onset of delirium must be carefully evaluated for adverse drug reactions, drug-drug interactions, and drug or alcohol withdrawal.

### Risk Factors

Numerous risk factors for delirium have been identified in several large prospective studies,<sup>5, 8-10, 13</sup> and age (> 70 years) is frequently associated with the onset. Tueth and Cheong<sup>14</sup> note that the "prevalence of delirium in older adults is a result of normal age-related physiologic changes and the increased incidence of illness and medication use in this population." Based on this work, normal physiologic changes that make the elderly more prone to delirium include:

1. Decreased albumin, liver function, and renal function increase the possibility of drug side effects due to changes in drug levels, metabolism, and clearance.
2. Neural loss, decreased cerebral perfusion, and decreased neurotransmitter and receptor levels may impair cognitive performance.

Poor cognitive function prior to admission to the hospital, severe underlying illness, vision impairment, dehydration, and abnormal sodium and glucose levels are the most common risk factors cited.<sup>5, 8, 9, 13</sup>

In addition to organic illness and medication effects, several "environmental" risk factors inherent to the ICU have been identified. These include the constant noise, foreign surroundings and people (ICU personnel), loss of day-night orientation, sleep deprivation, loss of privacy, sensory overload, and immobilization. Additionally, these patients have lost all control and are totally dependent on others for all of their needs.

### Treatment

The goal of treatment is to prevent injury to the patient and preserve indwelling tubes and intravenous lines. Initially, treatment is aimed at man-



aging behavior while identifying and treating the underlying cause of delirium. The workup of delirium should include a complete history, with special attention on medication and alcohol use, and review of recent hospital events, especially the initiation of new medication. A complete physical examination, laboratory tests, and x-rays should follow. Laboratory testing usually consists of complete blood count, electrolytes, liver function tests, arterial blood gases, and urinalysis. Urine or blood cultures may be indicated after these tests because underlying infection is a common etiologic factor. Although rarely performed, an electroencephalogram is almost always abnormal and may be helpful in the diagnosis. Delirious patients should be cared for in a quiet, well-lighted room, although limiting noise in the ICU may be difficult. Patients should be treated in a calm and reassuring manner. Familiar objects and family members may help calm patients. Consistent nursing staff over several days may help reorient the patient and develop a sense of trust. If these supportive measures fail, physical restraints may be necessary to prevent injury. However, restraints may have the adverse effect of exacerbating agitation and may also cause physical harm to the patient.<sup>17</sup> When necessary, the minimal amount of restraint to prevent injury should be used.

When supportive care and treatment of the underlying cause of delirium, if found, are insufficient for controlling symptoms, pharmacologic therapy may be necessary. Additionally, a severely agitated ICU patient at risk of accidental extubation or loss of invasive monitors needs rapid sedation for his own protection. When selecting any medication in the ICU, several factors must be considered: (1) onset of action, (2) half-life, (3) side effects, and (4) drug interactions. In the acute situation, a drug with rapid onset and short duration is preferable. Although this requires more effort, it allows rapid control of symptoms and titration of sedation. For similar reasons, the intravenous route of administration is favored. Compared with intramuscular injections, the intravenous route provides more rapid and consistent drug levels. Additionally, repeated injections, which may heighten agitation, are avoided. Currently, the two most common classes of drugs used to treat delirium are neuroleptics and benzodiazepines.<sup>1, 14, 16, 18</sup> Within these classes, haloperidol and lorazepam have several unique characteristics to recommend their use.

Haloperidol is a high potency neuroleptic

that is considered by some to be the drug of choice for treatment of ICU agitation and delirium.<sup>1, 14, 16, 18</sup> Haloperidol provides rapid control of symptoms, has a minimal effect on respiration, and a high therapeutic index, all of which are beneficial properties in the ICU.<sup>1, 16</sup> Some studies have suggested that intravenous dosing of haloperidol may be associated with a lower incidence of side effects when compared with oral or intramuscular use.<sup>18-20</sup> The onset of action is 10 to 20 minutes following intravenous dosing. The pharmacologic half-life is approximately 20 hours, although the clinic half-life appears to be 4 to 6 hours. Numerous dosing schedules have been proposed and are extensively reviewed elsewhere.<sup>1</sup> The typical loading dose depends on the severity of symptoms: 1 mg to 2 mg for mild agitation, 2 mg to 5 mg for moderate agitation, and 10 mg to 20 mg for severe agitation. If necessary, this dose may be repeated within 20 to 30 minutes. If symptoms persist after two doses, the amount should be doubled.<sup>1</sup> This loading dose usually calms the patient to a drowsy but arousable condition. Thereafter, a maintenance dose of 2 mg to 5 mg intravenously every 4 to 6 hours can be used. As with all ICU medications, dosage must be titrated to the individual patient, and the necessity of continued treatment must be assessed daily. Haloperidol has two serious side effects. As with all neuroleptics, the rare but uncommon idiosyncratic side effect of neuroleptic malignant syndrome may develop. This is characterized by rigidity, fever, autonomic instability, and mental status changes. Second, extrapyramidal side effects may occur. These are not dose-dependent, although the route of administration may be important. The incidence appears to be lower with intravenous dosing when compared with oral and intramuscular administration.<sup>20</sup> Therapy should consist of reduction or cessation of the medication and treatment with an anticholinergic agent (eg, diphenhydramine [25 mg to 50 mg IV]).

Lorazepam is unique among the benzodiazepines because it has no active metabolites and does not rely on the cytochrome P-450 system for metabolism.<sup>1</sup> Lorazepam has a rapid onset of action compared with haloperidol, but has a long half-life (15 to 20 hours). Like all benzodiazepines, it may be very useful if anxiety is a component of the patient's symptoms. Occasionally, patients may have a paradoxical reaction with increased confusion, agitation, hallucinations, or paranoia. The minimal cardiorespiratory effects may be very important in the ICU, especially

## The Delirious ICU Patient

when weaning a patient from the ventilator. Lorazepam has undergone extensive clinical studies, is largely well tolerated, and is considered by many to be the drug of choice. The usual initial dose is 2 mg to 4 mg intravenously, then 1 mg to 2 mg every 4 to 6 hours as needed.<sup>1</sup> Lorazepam can also be given as continuous infusion. When the combination of haloperidol and lorazepam is used, there may be some synergy, allowing a decrease in total drug usage with fewer side effects.<sup>1,19</sup>

Midazolam is a new benzodiazepine that has been very popular; however, reported experience in the ICU has been limited. Midazolam has a very rapid onset of action and a very short half-life (1 to 2 hours), which may allow better titration of effect. The initial dose is 1 mg to 5 mg intravenously over 10 to 30 minutes, then 1 mg to 2 mg every 1 to 2 hours, or as continuous infusion. At physiologic pH, midazolam becomes very lipophilic, and, with prolonged use, there may be accumulation in adipose tissues. Additionally, critically ill patients may not metabolize midazolam effectively.<sup>21</sup> These factors may account for the prolonged recovery time often seen with extended use in the ICU.

### Conclusions

Delirium is a common problem among critically ill patients, especially the elderly. It is often misdiagnosed and therefore subsequently undertreated. Prompt diagnosis and treatment are important because delirium is associated with increased morbidity and mortality. Initial therapy consists of management of symptoms while identifying and treating the underlying cause. Haloperidol and/or lorazepam are the drugs of choice.

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# Extensive Mononeuritis Multiplex as a Solitary Presentation of Polyarteritis Nodosa

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**P**olyarteritis nodosa is an uncommon systemic disease characterized by necrotizing vasculitis of small to medium sized muscular arteries. Although its presentation may be protean, 20% to 70% of patients will present with some type of central or peripheral neurological involvement. However, extensive mononeuritis multiplex as a solitary manifestation of polyarteritis nodosa is very rare. We present such a case along with a discussion of its significance in the overall diagnosis, treatment, and prognosis of polyarteritis nodosa.

## Case Presentation

A 67-year-old white female presented to her internist's office with a 1-year history of progressive hearing loss and hoarseness. She had previously been seen by an otolaryngologist who had confirmed bilateral sensorineural hearing loss, unilateral serous otitis media, and normal vocal cords. She had no significant past medical history other than a history of borderline hypertension. Her review of systems was otherwise entirely unremarkable. Her physical examination on presentation was notable only for a blood pressure of 145/92, the aforementioned bilateral hearing loss, and obvious hoarseness. Initial laboratory evaluation including complete blood count, complete chemistry analysis, urinalysis, and thyroid function tests were all within normal limits. Chest radiograph was also normal. Over the ensuing 3 months, the patient's hearing loss progressed significantly and her dysphonia progressed to severe dysphagia with concomitant episodes of aspiration. This ultimately progressed to the point where the patient was completely unable to swallow and she was admitted to her local hospital for evaluation. Her course at that time progressed to include weakness of both upper and lower extremities. On that

admission, the patient underwent an extensive neurological examination including magnetic resonance imaging of the brain and cervical spine, lumbar puncture, complete blood chemistries, repeat thyroid function tests, anti-nuclear antibody titers, rheumatoid factor, computed tomography of the chest, abdomen, and pelvis, and electroencephalogram. All were within normal limits. Serum aldolase was mildly elevated and serum creatinine phosphokinase was normal. Ultimately, her extremity weakness progressed, and a muscle biopsy was performed which was consistent with polyarteritis nodosa.

The patient had a gastrostomy tube placed for nutritional purposes and was started on cyclophosphamide and methylprednisolone. Her early course was complicated by aspiration pneumonia, from which she successfully recovered. Over a 2-month period, her weakness improved dramatically to the point where she was able to ambulate with the minimal assistance of one person. Her hearing loss also improved significantly, but the patient remained dysphonic and dysphagic despite aggressive speech therapy. Unfortunately, the patient ultimately suffered a second occurrence of significant aspiration with resultant overwhelming pneumonia and progressive multiple systems organ failure. She expired and no post-mortem examination was allowed.

## Overview of Polyarteritis Nodosa

Polyarteritis nodosa (PAN) is an uncommon disease with a prevalence of 6 per 100,000. PAN is a systemic necrotizing vasculitis of small and medium sized muscular arteries. First polymorphonuclear leukocytes and then mononuclear cells infiltrate the vessels and surrounding tissue. Inflammation of the vessel wall may cause narrowing, thrombosis, or aneurysm formation. Le-

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sions heal with proliferation of fibrous material that may lead to luminal occlusion and tissue ischemia.<sup>1</sup>

Polyarteritis presents in a variety of ways. Systemic symptoms of weight loss, fever, myalgias, anorexia, and malaise are common. Organs most frequently involved include kidney, gastrointestinal tract, nervous system, skin and joints.<sup>2</sup> Cohen et al studied 53 patients for at least 2 years and observed that renal and gastrointestinal involvement most adversely affected prognosis. Renal involvement manifests as a glomerulitis or a necrotizing arteritis and is the most common cause of death. Gastrointestinal involvement may present as abdominal pain, bleeding, or infarction and perforation with catastrophic consequences.<sup>3</sup>

Diagnosis is based on information gained by simple noninvasive tests in combination with definitive diagnosis by biopsy or arteriography. The following studies should be obtained initially: complete H&P, complete blood count, ESR, BUN and creatinine, urinalysis for RBCs and protein, and CPK. Other tests, including electromyography and nerve conduction studies may be ordered if indicated. For pathologic diagnosis, patients with symptomatic muscles or nerves should have biopsies of involved sites. Arteriography should be undertaken if biopsy results are unrevealing. Patients without symptomatic muscles or nerves should undergo mesenteric angiography with sequential inspection of the celiac, superior mesenteric and renal beds. If the results of angiography are negative, blind muscle biopsy should be performed. Albert et al found this approach to confirm the diagnosis of polyarteritis in more than 80% of patients.<sup>4</sup>

The treatment of polyarteritis nodosa includes the use of both immunosuppressive and cytotoxic agents. Prednisone is instituted at a dose of 1 mg/kg and is tapered over a 6 to 18 month interval. Cyclophosphamide is given in doses of 1-2 mg/kg and is continued for approximately 1 year.<sup>5</sup> Untreated patients have a 5-year survival rate of 13%.<sup>6</sup> The current 5-year survival in patients treated with steroids is 55% and several authors have observed that the addition of cyclophosphamide improves the outcome.<sup>7</sup> Other authors have shown no improvement in overall survival with the addition of cyclophosphamide.<sup>3</sup> It is generally agreed that cytotoxic therapy should be added in patients with more widespread and extensive disease and in patients not responding to steroids alone.

## Neurologic Involvement

Both central and peripheral nervous system involvement are observed in PAN. CNS abnormalities occur in 20% to 40% of patients and tend to occur late in the course of disease. CNS involvement includes a spectrum of disorders, diffuse and focal. Encephalopathy is the most frequent manifestation of CNS involvement and may be characterized by loss of intellectual capacity, disorientation, or psychosis with visual hallucinations. Uncontrolled hypertension resulting from the vasculitis and high dose corticosteroid use must be considered in the differential diagnosis of a patient who develops encephalopathy. The encephalopathic manifestations tend to resolve more rapidly than the other CNS manifestations.<sup>8</sup> Generalized or focal seizures may occur in the presence or absence of encephalopathy. Focal symptoms are caused by ischemic or hemorrhagic stroke. These may occur in the cerebral hemispheres, brainstem, cerebellum, or spinal cord. The late occurrence of CNS involvement suggests that chronic vascular scarring, rather than acute inflammation, is the mechanism of ischemia.<sup>1</sup>

Cranial nerve palsies have been described, but are rare case reports in the literature. Ocular abnormalities involving the third, fourth, and sixth cranial nerves have been documented. Facial nerve palsy has been reported in a few cases and has responded to treatment with prednisone and cyclophosphamide.<sup>10,11</sup> Hearing loss is a rare complication, resulting from eighth nerve involvement or serous otitis media. Some authors have shown improvement in hearing after initiation of treatment with steroids and cytotoxic agents.<sup>9,10</sup>

Peripheral neuropathy is the most frequent form of neurologic involvement and occurs in 60% of patients with PAN. In contrast to CNS involvement, peripheral neuropathy tends to occur early in the disease and is frequently the presenting symptom. Small to medium sized epineural arteries of nerve trunks are involved by the vasculitic process.<sup>13</sup> Moore and Fauci described four types of peripheral neuropathy in PAN including: (1) mononeuritis multiplex (2) extensive mononeuritis multiplex (3) cutaneous neuropathy (4) polyneuropathy. *Mononeuritis multiplex* presents as motor or sensory deficits in more than one peripheral nerve in a random distribution. This was the most common type of neuropathy, found in five of 20 patients with PAN associated peripheral neuropathy in Fauci's study. *Extensive*

*mononeuritis multiplex* was defined as flaccid weakness and multimodality sensory loss in one or more extremities. Deficits were widespread and specific involvement of individual peripheral nerves frequently could not be discerned. In the patients presenting with areas of hypesthesia or paresthesia (*cutaneous neuropathy*), the digits of the hand and soles of the feet were most frequently involved. Distal sensorimotor deficits were most frequently found in the lower extremities and other causes of distal *polyneuropathy* were ruled out. *Radiculopathy* and *brachial plexopathy* have also been reported in association with PAN, but were not seen in the patients in this study.<sup>12</sup>

### Neurologic Involvement as an Isolated Manifestation of Polyarteritis Nodosa

The patient in our case presentation developed cranial nerve involvement and extensive mononeuritis multiplex as the presenting and only manifestation of PAN. No clinical evidence of renal, gastrointestinal, skin, or joint involvement developed. Neurologic involvement as the only presentation of PAN is rare, but has been reported in a few studies in the literature. Of the 20 patients in Fauci's study with neurologic complications, only three had a neuropathy as the sole presentation of PAN, however all three patients later developed other complications of PAN.<sup>12</sup> Kissel et al reviewed 350 consecutive nerve biopsies performed at Ohio State University over a 10-year period. Sixteen of the biopsies showed a necrotizing arteritis. Nine of these patients had exhibited other non-neurological manifestations of collagen vascular diseases and vasculidities. The remaining 7 demonstrated only a necrotizing arteritis without other serologic or clinical abnormalities.<sup>13</sup> In a study of 100 patients who were found to have neuropathy associated with nerve and muscle biopsy proven necrotizing angiopathy, 68 also had evidence of non-neurologic vasculitic involvement such as arthritis, renal involvement, and rash. The remaining 32 patients presented with neurologic involvement alone. The authors speculated that isolated neuropathy may occur because ischemia, even when limited to a short segment of nerve, may induce symptoms, whereas a lesion of the same size may remain silent in other organs. Long-term follow-up of cases with isolated neurologic involvement will be necessary to observe whether non-neurologic manifestations of PAN develop in this subset of patients who survive and are observed for several years.<sup>14</sup>

### Response to Therapy

As stated previously, prednisone with or without cyclophosphamide is the most widely accepted treatment for PAN. Corticosteroids greatly increase the 5-year survival rate from 13% to 55%. Although cytotoxic agents have not shown statistically significant increases in survival in many studies, it should be noted that the patients selected to receive cyclophosphamide had more serious visceral involvement.<sup>3</sup>

Patients with neurologic involvement show marked improvement with standard therapy. Unfortunately, only case reports are available to assess response to therapy in patients with neurologic complications of PAN. In Fauci's study of the 20 patients with PAN and neurologic involvement, several had neurologic events while receiving steroids alone, but none showed progression or new occurrence of neurological disease while receiving cyclophosphamide. Most patients made dramatic recoveries with medical treatment and physical therapy. Two of the 5 patients with mononeuritis multiplex had complete recovery, 1 had moderate recovery, 1 died 4 months after the onset of illness and 1 had insufficient follow-up. All 3 patients with extensive mononeuritis multiplex were quadriplegic. Their recovery was slow but dramatic. Within 3 years, all were able to ambulate with either braces or a cane. The 2 patients with sensorimotor polyneuropathy improved in strength, but sensory deficits persisted while on treatment. The cutaneous neuropathies failed to respond to treatment, but were mild and not very bothersome to the patients. Other studies have shown complete recovery of hearing and cranial nerve palsies with early treatment.<sup>9,10,11,15</sup>

### Conclusion

Polyarteritis nodosa may rarely present with neurologic involvement as the sole manifestation of disease. Diagnosis can be made with pertinent clinical information and biopsy results confirming a necrotizing arteritis. Early diagnosis and treatment of most patients with prednisone and cyclophosphamide has been shown to greatly reduce morbidity and mortality in polyarteritis with and without neurologic manifestations.

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# Delayed Diagnosis of Congenital Adrenal Hyperplasia in a Premature Female Infant

Teddy V. Dela Cruz, MD; Duncan R. MacMillan, MD; Ramona M. Browning, MD; Dan L. Stewart, MD

*A preterm female infant was diagnosed with congenital adrenal hyperplasia after the first month of life. Electrolyte abnormalities and prominent clitoris were originally attributed to the prematurity of the infant. Congenital adrenal hyperplasia was confirmed when the abnormalities persisted. Delay in diagnosis can be prevented with the installation of newborn screening programs.*

Adrenal insufficiency is suspected in the newborn infant with persistent hyponatremia and hyperkalemia. If these electrolyte abnormalities are associated with a prominent clitoris and labioscrotal fusion, congenital adrenal hyperplasia is suspected. In the most common form of CAH (21-hydroxylase deficiency), the diagnosis is confirmed when an elevated level of 17-hydroxyprogesterone is measured.<sup>1</sup> However, in premature female infants, the diagnosis of CAH is more difficult since a prominent clitoris is normally present and salt loss in the first few days of life may be caused by renal immaturity.<sup>2,3</sup>

We report a case of CAH in a premature female infant whose diagnosis was made after the first month of life.

## Case Report

A female infant, weighing 760 g, was delivered at 28 weeks' gestation to a 33-year-old gravida 3, para 2, healthy woman. The pregnancy was complicated by premature rupture of membranes that occurred over 48 hours before delivery. Presumed chorioamnionitis was treated with ampicillin. The mother denied any exposure to androgens or other teratogens during the pregnancy, and there was a negative family history for CAH. The infant was delivered by emergency Caesarean section

because of fetal decelerations. Endotracheal intubation was required in the delivery room, and Apgar scores of 5, 6, and 8 at 1, 5, and 10 minutes, respectively, were assigned.

The initial physical examination was consistent with that of a premature female infant at 28 weeks' gestation confirmed by modified Ballard score. The infant was treated with exogenous replacement surfactant and assisted ventilation for hyaline membrane disease, indomethacin for a patent ductus arteriosus, phototherapy for hyperbilirubinemia, and theophylline for apnea and bradycardia.

The first month of life for the infant was complicated by persistent hyponatremia and hyperkalemia, despite total parenteral nutrition and later enteral nutrition. Early during the course of treatment, the infant required as much as 18 mEq/kg/d of sodium supplements parenterally to maintain sodium values between 135 to 140 mEq/L. A normal requirement in the premature infant is 2 to 3 mEq/kg/d. As the infant was gradually weaned from parenteral nutrition to a preterm infant formula, she required increasing amounts of daily sodium supplements added to her feedings. To maintain normal sodium values, the infant's daily requirements for sodium supplements while receiving enteral nutrition were as high as 12 mEq/kg/d.

Concomitantly, potassium values (obtained by venous sampling and without supplementation) were elevated to 7.5 mEq/L on repeated measurements, requiring treatment with Kayexalate enemas until the potassium values were less than 6.0 mEq/L. After discontinuing Kayexalate enemas, potassium values were intermittently elevated to 6.5 mEq/L. No cardiac arrhythmias were noted, and renal function and blood pressure were normal.

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# Congenital Adrenal Hyperplasia



**Fig 1 — Physical findings of clitoromegaly and labioscrotal fusion at one month of life.**

After the first month of life, electrolyte abnormalities persisted despite sodium supplementation. Also, what initially was interpreted to be immature female genitalia, now proved to be a virilized clitoris with labioscrotal fusion (Fig 1). After appreciation of these physical findings, an evaluation for ambiguous genitalia was initiated. This evaluation included repeat determination of serum electrolyte values, pelvic ultrasound, vaginogram, chromosome studies, 17-OHP level, and consultation with a pediatric endocrinologist.

The laboratory and radiographic findings confirmed the diagnosis of virilizing congenital

adrenal hyperplasia with a 21-hydroxylase deficiency in a premature infant with normal female karyotype. Treatment with cortisone and Florinef was initiated. Sodium supplements were decreased to 1 to 2 mEq/kg/d to maintain appropriate sodium values. The 17-OHP level continued to decrease with appropriate adjustments of medications (Table 1). Follow-up when the infant was 5 and 10 months old showed normal growth and development. Physical examination was normal, except for the presence of a prominent clitoris and labioscrotal fusion which will require plastic surgery in the future. The infant continues to require cortisone and Florinef.

## Discussion

This case illustrates the difficulties in the diagnosis of CAH in premature female infants. Our patient demonstrated signs of virilization and electrolyte abnormalities in the first weeks of life, but this was attributed to the prematurity of the infant. However, as these findings persisted, CAH was suspected. A serum 17-OHP value was elevated when compared with values reported by Knudtson et al.<sup>2</sup> After cortisone and Florinef were initiated, the 17-OHP value decreased to an acceptable level and minimal sodium supplementation was needed.

Since 1977, screening for CAH has been available as part of routine newborn screening programs in several states and countries.<sup>4</sup> The average additional cost for such screening is \$1.16 per patient.<sup>4,5</sup> This additional cost is small when compared to the cost of hospitalizing a symptomatic infant with CAH who presents with dehydration, electrolyte abnormalities, or adrenal crisis. Without the availability of a newborn screening program for CAH in most states, the presence of ambiguous genitalia with hyponatremia and hyperkalemia should suggest that further etiologic testing is necessary.

In our case, several factors contributed to the delay in diagnosing CAH. First, an investigation of an etiology for persistent hyponatremia was not undertaken despite increases in sodium supplements. Second, the ambiguous genitalia were not appreciated until the infant was 1-month-old. Physical examinations were performed each day, but the genitalia were considered a normal variant in premature female infants. Finally, a newborn screening program for CAH does not exist in Kentucky. If appropriate newborn screenings had been performed, the diagnosis of CAH would

**Table 1. Laboratory values\***

Time of Sample	17-OHP (ng/ml)	DHEA (μg/dl)	Cortisol (μg/dl)	ACTH (pg/dl)
At diagnosis	116.20	413.4	14.8	—
12 days after therapy	12.50	111.1	37.4	—
30 days after therapy	19.80	—	—	—
3 months after therapy	4.70	—	—	13.8
10 months after therapy	2.37	—	—	—
Normal values	0.4 to 4.8	5 to 55	6 to 36	ND to 37

\* All specimens were serum samples.

17-OHP, 17-hydroxyprogesterone; DHEA, dehydroepiandrosterone; ACTH, adrenocorticotrophic hormone; ND, none detected.



have been made earlier.

This case illustrates the importance of searching for etiologies for recurring electrolyte abnormalities in premature infants and the need for the establishment of newborn screening programs in all states to identify those asymptomatic infants at risk for congenital adrenal hyperplasia.

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# CAGE Questionnaire

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**C** = Have you ever felt you should **cut down** on your drinking?

**A** = Have people **annoyed** you by criticizing your drinking?

**G** = Have you ever felt bad or **guilty** about your drinking?

**E** = Have you ever had a drink first thing in the morning (**eyeopener**)?

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Positive CAGE Answers:

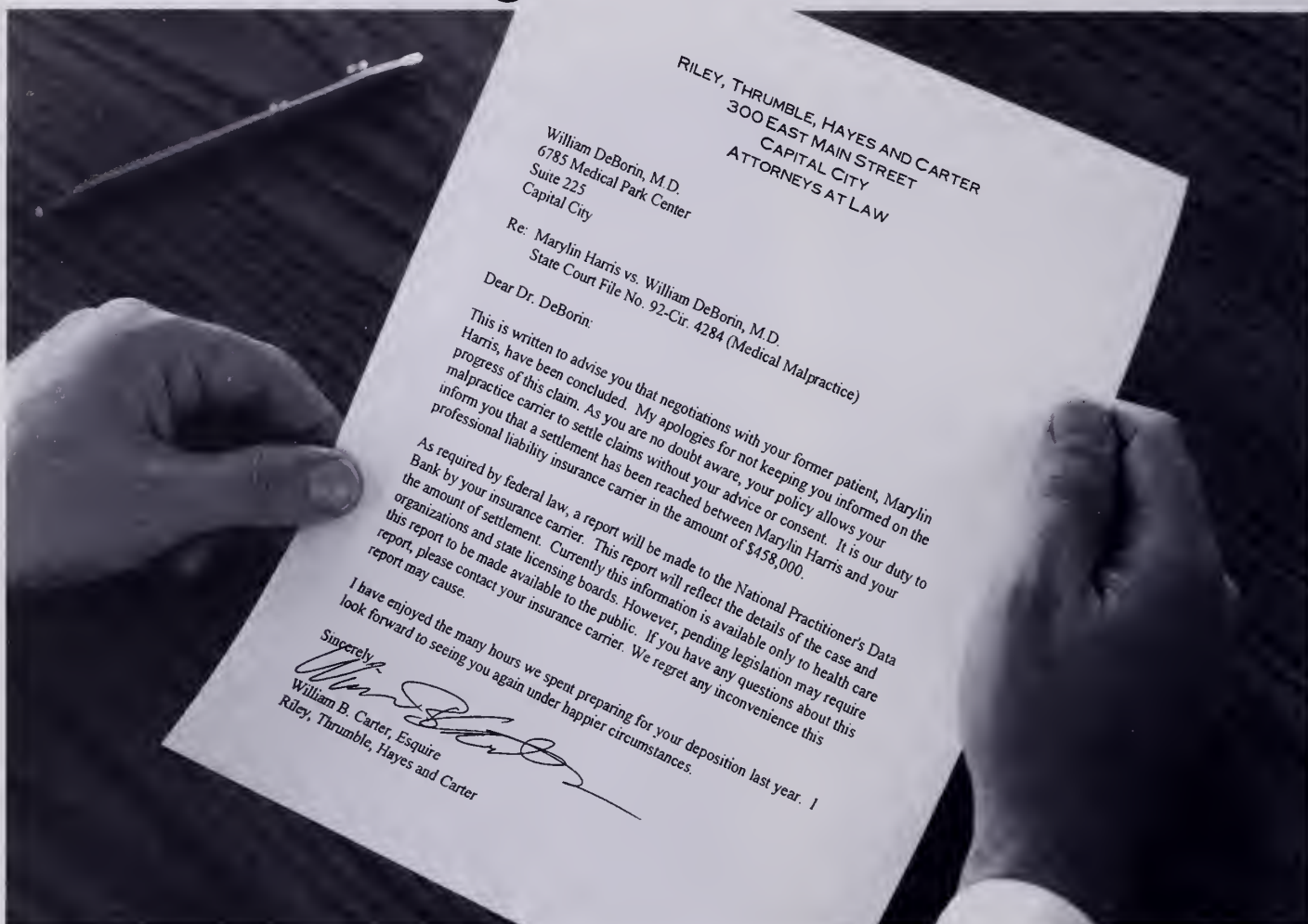
1 = Suggestive 2 = Probable 3 and/or 4 = Diagnostic

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# How to Avoid Burnout in Medical Practice

John J. Schwab, MD

Hippocrates' famous aphorism applies to a career in medicine which, during the past 20 years, has become an "experiment perilous." Moreover, a discussion of the perils of medicine as a career is difficult because it is so subjective — we are talking about ourselves. In this article, my purposes are to present a few data on physician impairment, discuss the burnout syndrome, and then list some strategies to prevent it.

## Overview of Impairment

The historic 1972 AMA report on "The Sick Physician" drew attention to the generally ignored problem of physicians impaired by physical or mental illness, including alcoholism or drug dependence.<sup>2</sup> Since 1972, when only 7 state medical societies had impaired physician programs, the number has grown steadily. By 1982, 47 medical societies had such programs; however, as Smith and Steindler pointed out, although there had been concerted activity, "psychiatric disorders of physicians have not been uncovered, diagnosed, and treated to the extent of other disorders attributable to stress such as alcoholism and addiction."<sup>3</sup> In 1982, McCue emphasized: "Each day physicians encounter stresses that are an intrinsic part of medical practice."<sup>4</sup>

At the end of still another decade, by the early 1990s, practically all state medical societies had impaired physician programs, but the problem of physician burnout had grown and impairment rates had increased. For example, a 1975 AMA report indicated that 5% to 6% of physicians in the United States

*Life is short, the art is long, experiment perilous, and judgment difficult.*

— HIPPOCRATES<sup>1</sup>

were impaired because of alcohol or drug addiction.<sup>5</sup> The reported percentages are now higher. For alcohol dependence/abuse they ranged from 6.0% in Hughes and his colleagues' 1992 survey to Moore and his associates' 1990 report of 12.9% of the 1,014 Johns Hopkins School of Medicine graduates from 1948 to 1961 who had been followed almost annually.<sup>6,7</sup> The percentage of physicians dependent on or abusing drugs has been an increasing concern during the past decade. It is in the 3% to 4% range and the percentage using the spectrum of illicit drugs from marijuana to cocaine for recreational use is about 10%.<sup>8</sup> Unfortunately, we still do not have reliable data about the prevalence of mental illness in physicians, but as Smith and Steindler noted in 1982, about 25% of physicians surveyed had histories of treating themselves with psychoactive drugs.<sup>3</sup> Overall, current national estimates are that 10% of physicians throughout the USA are impaired.<sup>9</sup>

The physicians' plight presented by the bare statistics is not limited to such scientific evaluations. In 1908, in his drama, *The Doctor's Dilemma*, George Bernard Shaw took note of the long hours physicians work and the stresses of their work. He asked: "Why don't the impatient doctors become savage and unmanageable, and why don't the patient ones become imbeciles? Perhaps they do to some extent."<sup>10</sup>

## Impairment and Suicide

Those percentages referring to alcohol and drug dependence or abuse and to impairment testify to the severity of the problem of burnout which, too often, results in suicide. A physician's death by suicide is a tragedy for family and friends and a loss to the society that educated him or her and rightfully expects dedication and service. Although the precise number of physician suicides is not known, the rate in 1992 was probably between 28 and 40 per 100,000, much higher than the national rate of about 11.6 per 100,000, but only somewhat higher than the rate of 31 per 100,000 for men age 25 plus years.<sup>11</sup> We need to consider two other facts. First, there is little doubt that the physician suicide rate universally is greater than is known because physicians have special knowledge of and access to lethal methods. Moreover, for both male and female physicians the percentage of successful initial suicide attempts is exceptionally high, 62%.<sup>12</sup> Second, the suicide rate among female physicians is increasing, and although it is only slightly higher than the rate for males, it is four times greater than the rate for females age 25 plus years. About 6.5% of all female physicians' deaths are by suicide in contrast to 3% of all male physicians' deaths.<sup>11</sup> Generally, the number of suicides each year is equivalent to the loss of two medical school graduating classes.

Concern about the physician suicide rate led to the development of the well-designed, case-control collaborative AMA-APA Physician Mortality Project that was reported in 1987.<sup>13</sup> Major findings were that the average age for



## Burnout in Medical Practice

suicide was 49.3 years (the prime of the physician's professional life); 69% were married and 22% were separated or divorced; 69% were actively practicing compared to 67% of controls; and, women physicians accounted for a disproportionately large percentage of the suicides. The highly significant risk factors for suicide were:

1. A history of mental illness, especially depression, and of previous treatment;
2. A previous suicide attempt;
3. Family history of mental illness;
4. Violence toward spouse; and
5. Self-prescribed psychoactive drug use.

The report concluded that the physician in danger of suicide often verbalizes his or her intention, is emotionally distressed, has a history of both physical and mental health problems, exhibits alcohol-related social problems, and may be seeking to avoid further mental pain.<sup>13, 14</sup>

## The Burnout Syndrome

The burnout syndrome was described in 1974 by Freudenberger, a busy psychiatrist in San Francisco.<sup>15</sup> He stated that the inability to conserve energy and to adapt efficiently lead to burnout — "to fail, wear out, or become exhausted by reason of excessive demands on energy, strength, or resources."

The syndrome consists of somatic, psychological, and interpersonal symptoms and signs. The somatic include exhaustion, fatigue, headaches, gastrointestinal disturbances, insomnia, and shortness of breath. Major psychological symptoms are depressed mood, irritability, anxiety, rigidity, negativism, cynicism, and a lack of curiosity. The interpersonal signs are a quickness to anger, an irritability that keeps others off balance, suspiciousness, defensiveness, the attributing of fault to others, lack of tolerance, authoritarianism, and a discouragement that may spread to others. Freudenberger described the typical victim of burnout:

The person who used to be the talker, the contributor at staff meetings now remains silent, sits in the corner and says nothing; the person appears to be resentful, disenchanted, fatigued, bored, discouraged, and confused; the burnout victim appears edgy, quick to anger, and frustrated at what would ordinarily be something of mild importance.<sup>16</sup>

The burnout syndrome is a professional stress syndrome. Repeated studies indicate that more than 50% of physicians report that their work is stressful.<sup>17</sup> The burnout syndrome is not just job dissatisfaction; burnout develops in persons who are highly committed to their jobs whereas dissatisfaction has little to do with dedication or striving. When overwhelmed by excessive demands, the physician's performance becomes disorganized and effectiveness decreased. He or she uses distancing maneuvers for protection, for example, by treating patients "strictly by the book," shortening interviews, imposing derogatory labels on patients, and decreasing eye contact and friendliness. As the physician becomes more detached and emotionally withdrawn, and as his or her defenses weaken, discouragement and symptoms appear and behaviors become increasingly maladaptive.

In summing up his 36 years of experience with the treatment of 250 emotionally ill physicians at the Institute of Pennsylvania Hospital, Pearson stated:

In general, it could be said that the most prominent early sign of emotional disturbance in many of these patients was the manner of their hurried existences. As the years went by, their everyday lives generally became progressively more chaotic, insofar as regulated office hours, . . . regular sleeping and eating habits, and the acceptance of family responsibilities were concerned.<sup>18</sup>

His physicians' lives were characterized by a great deal of masochism as evidenced by a chronically self-destructive faulty work life with long hours and poor organizational habits. Further-

more, many of the physicians did not schedule vacations, did not engage in physical activity, and, in reality, lived a constricted existence; they read few medical books or journals and attended few or no medical meetings.

## *The Effect of Burnout on the Physician's Family*

The protracted stress at work and the physician's burnout and emotional distress are not confined to the office or to the hospital. McCue emphasized that the spouse and children have to function as a "support system" for the doctor and try to be his or her "battery rechargers."<sup>4</sup> But as burnout becomes more intense, the doctor withdraws emotionally from family life. Vaillant and his associates reported that about 50% of the disturbed physicians they studied experienced marital maladjustment characterized by a sense of instability in the relationship, sexual dissatisfaction, or consideration of divorce.<sup>19</sup> Other investigators point to the high frequency of marital conflicts and children's problems in families of overstressed physicians.<sup>20, 21</sup> The physician tends to attribute the problems to the family relationships and then the entire family suffers. The spouse reports frustration and anger followed by bouts of guilt and depression. Each partner becomes isolated and feels that he or she is not understood and there is increasing emotional withdrawal and social isolation. Some spouses resent the degree of attention and concern the physician shows to patients compared with the apparently small amount they receive. The children become aware of their parents' difficulties and feel more and more distanced from the family. They resort to attention-seeking or to such behaviors as stealing or drug or alcohol abuse. Occasionally, the children confront the parents, but, more often, they act out their problems and disdain medicine as a career and as a profession. The doctor's family is one new area in need of research on its problems and the development of strat-

egies to reduce dysfunction, instability, behavioral difficulties, and divorce.

#### *Development of the Burnout Syndrome and its Consequences*

It is not surprising that the concept of the burnout syndrome in medicine has been recognized only during the past 20 years. Physicians trained during the 1960s and 1970s received an education based almost exclusively on the biomedical model of disease which, along with developments in science, resulted in a de-emphasis of the art of medicine. Extreme reliance on laboratory examinations and on specialized diagnostic techniques have led to views of, and interaction with, patients as if they were bits or parts of machines, not whole human beings.<sup>22</sup>

These developments have had four consequences. One is that physicians have been deprived of the gratification that can be obtained from working with patients who are seen as individuals, each with his or her uniqueness. Another is that patients feel they are objects, not humans, and their consequent frustration and resentment further impair the doctor-patient relationship, limit their gratitude and respect, and contribute to litigation problems. A third is that developments in scientific medicine did little to help physicians' work with patients suffering from psychophysiologic illnesses and emotional distress. Such patients, who constitute about one-third of all persons seeking general medical care, present with baffling mixtures of somatic, psychological, interpersonal, and social complaints that can neither be diagnosed nor treated by technological medicine. McCue insisted: "Physicians are rarely taught the techniques needed to take care of this kind of patient or to understand their own complicated feelings toward them."<sup>24</sup> Thus, physicians are overwhelmed by demands that they cannot meet and frustration and stress increase.

Fourth, in addition to the rapid developments in science and the necessity to keep abreast of new information,

the practice of medicine has changed drastically during the past two decades. The physician now practices in a highly regulated situation under the threat of malpractice suits, and is compelled to spend a great deal of time and effort conforming to both the implicit and explicit demands of medical and insurance company administrators and agencies as well as patients. Those factors plus the necessity to fulfill the complicated roles required by medical practice contribute to the emergence of the burnout syndrome.

#### **Causes of Burnout**

To avoid burnout it is necessary for us to look briefly at major factors responsible for it. They stem mainly from: (1) work; (2) others' expectations of their doctors; and (3) the individual or personal factors. In many ways the three are intertwined.

##### *Work*

The work-related are the easiest to describe. They consist of overwork, concern about coping with the immense variety of problems presented by patients, the care of patients with chronic illnesses, the blurring and diffusion of roles that make it necessary to be an administrator and business person as well as a physician, and the hassles with control by insurance companies and government agencies. The resulting overwork sets in motion a complicated chain of events that begins with an increased sense of self-importance and some tangible returns that allow the physician to avoid problems at home. Unfortunately, reinforcement leads to conditioning and later to symptom formation and often self-treatment, substance abuse, and sometimes suicide to escape the suffering.

##### *Expectations*

Since World War II, expectations of physicians and of medicine have become unrealistically high. The publicity given advances in medicine has resulted in physicians' working with more edu-

cated and sophisticated patients than in the past and with many who do not understand why the latest scientific advances do not cure them. Also, the standards for the physician as a citizen, an employer, a colleague, a parent, and a spouse are generally higher than the standards set for many other members of the community. When the physician is unable to live up to these high, and often unrealistic, expectations, he or she experiences inadequacy, a sense of failure, and frustration. The discrepancies between unrealistically high standards and one's capabilities are especially conducive to burnout, particularly when the physician is overworking.

##### *The Personal*

The individual or personal factors producing burnout are probably the most important because they involve the quality and type of adaptation utilized by physicians in response to stress.<sup>20, 21</sup> It is almost redundant to label the practice of medicine stressful. Moreover, it is unlikely to be otherwise in the near future. Thus, there are many factors that we cannot change, but what a physician can change is the way he or she adapts to stress. To put the quality of the adaptation needed in perspective, it is wise to recall that almost all persons entering medicine are high achievers. They know that they are an able, selected group who have worked hard, postponed gratification, are expected to serve and help others, and, eventually, to be rewarded.

We need to acknowledge that medical education requires the elaboration of personal defenses and the practice of medicine the use of defenses to maintain the ability to work and to achieve the equanimity that Osler prized.<sup>23</sup> Merely obtaining admission to medical school at any time since World War II has been a grueling ordeal demanding the demonstration that one can achieve. After entering medical school and enduring the initial anxiety, the student must construct defenses to adapt. As I look back, I am amazed at



## Burnout in Medical Practice

the amount of denial that most of us began to use when we started gross anatomy. As we dissected a human body — took it apart until practically nothing was left but some shreds, fibers, and bones — we learned to deny that that cadaver was once a living being who had felt pain and happiness and faced life with tears and laughter. The student is compelled to diminish his or her awareness of the fragility of the human body and of the frailty of one's own existence. Later, during the clerkship years, the student must become inured to the blood and grime of disease and death and deny that he or she, too, will someday be a patient, suffer like other patients, and ultimately be afflicted with the disease processes that we get to know in detail. In medical school, physicians develop the denial that carries over to their professional and personal lives, and learn to use it to too well. It limits awareness of the development of burnout and deprives the physician of the introspection needed to mount the healthful coping processes that prevent or alleviate burnout.

Consideration of the stressors sustained for years by the individual who is first a student, then a trainee, and later a practitioner leads to questions about why burnout is not more common. One explanation is that physicians are a highly selected, generally healthy group who learn to use defense mechanisms for coping with as well as for enduring stress.

### Prevention of Stress and Burnout

The prevention of stress and burnout involve more than the age-old admonition, "physician, heal thyself." It requires continuing awareness of one's self and the use of self-imposed strategies. These include:

1. Enhancing awareness of not just what one is doing and how one is acting, and reacting, but also of one's effect on others at work and at home. Obtaining heightened awareness entails evaluating one's motivation and

asking specific questions: What personal needs am I trying to meet? Am I using my work to meet needs that should be fulfilled elsewhere in my life? To what extent is my sense of well-being dependent upon bringing about significant changes in my patients? Are my goals realistic? And, perhaps most importantly, do I acknowledge my own limitations? Finding reasonable answers to those questions thus involves an examination of one's life. Physicians need to recall Socrates' insistence that the unexamined life is not worth living.<sup>24</sup>

2. Setting goals that do more than just limit the amount of time and energy devoted to professional activities. Limited goal setting can minimize fears of failure, foster feelings of self worth, and allow for greater appreciation of one's daily accomplishments and contributions.

3. Developing meaningful relationships with professional colleagues to increase communication with others who are likely to understand feelings about and reactions to professional stress. Being with peers and sharing problems enables one to see that he or she is not alone, that one's problems usually are dilemmas for other physicians as well. Also, engaging in activities and other collaborative work with associates enhances one's professional identity and sense of belonging and being connected.

4. Attending and participating in professional meetings to keep up with developments in medicine and to stimulate intellectual curiosity. In his short essay, "Can the Practice of Medicine be Fun for 30 Years?,"<sup>25</sup> Guze concluded that the answer would be in the affirmative when the physician maintained vigorous intellectual interests in medicine and its exciting developments.

5. Scheduling physical activity. Regular participation in exercise programs promotes a general sense of well-being, not just by becoming physically fit, but also, because exercise increases healthful cerebral functioning. We need to bear in mind Juvenal's old Ro-

man adage: "A sound mind in a sound body."<sup>26</sup>

6. Devoting the requisite time and energy to hobbies or recreation that involve activities different from work and offer a variety of pursuits for intellectual and other energies. They are urgently needed also to supply diversion and lightness in living that counterbalance the excessive concentration and the seriousness required by patient care and other professional activities. Also, involving oneself in community or cultural activities can enhance the self-concept and increase interest in spheres beyond the self. Such cultural pursuits as art, drama, or music stimulate sublimation and help us realize Browning's words: "Man's reach is beyond his grasp."<sup>27</sup>

7. Taking time not just for vacations but also for a 72- to 96-hour "break" away from work at least once a month. Regular departures from the professional routine can rejuvenate physicians who are beginning to be burned out. It is wise to recall that nature's stress remedies are adequate sleep, healthful exercise, nutritious food, diversion and recreation, and the good company of others.

8. Increasing one's dedication to family life. As this century draws to a close, there is nationwide concern about the instability and troubled status of the American family. The continuing high divorce rate, the extent of family violence, young persons' fears of marriage and commitment, and the proliferation of "relationship problems" and what are euphemistically termed alternative life styles and living arrangements all attest to the validity of the concerns. The heightened concern encompasses the plight of many children of divorce and the behavioral pathologies that include drug abuse and delinquency. Many patients seeing physicians and surgeons in the various specialties and fields of practice are worried about or are in the throes of distress about marital and family problems. Physicians and their families are not immune to what has become the

"multiproblem epidemic affecting families."<sup>28, 29</sup>

The greatest regret expressed by most physicians I have known or seen professionally is that they relegated to secondary importance the satisfactions in living that stem from the quality of the physician's relationship with his or her spouse and children and the flow of feelings back and forth among them. Those satisfactions, other feelings, and family work and play are the human connections in Lovejoy's "Great Chain of Being."<sup>30</sup>

9. Participating in or at least attending some type of religious, spiritual, or metaphysical activity that enables us to look at the fundamentals of human existence, especially meaning and values, and human beings' relationships with each other and to God.

10. Making a change, when necessary, in the type or amount of work or the work setting. Research with burned out physicians shows that reduction of only one or two stressors can restore homeostasis. It is not necessary to re-vamp one's entire life and work to achieve the needed physical, emotional, interpersonal and spiritual equilibria. However, when physicians make reasoned, judicious changes in the type or place of work, almost always, they report that change was beneficial, especially when it was well planned.

The successful use of these suggested strategies depends on the increased self-awareness and introspection that are possible when one has the courage and the wisdom to strip away denial. The strategies are directed toward the three spheres of human existence: (1) the self and one's identity; (2) relationships with others; and (3) connections with nature and with the spiritual domain. And they include some changes in activities and modifications or developments of attitudes and views on life. Thus, to avoid stress and burnout, physicians are compelled to heighten awareness of their physical, interpersonal, and spiritual selves and to accept change and process as being intrinsic to well-being as well as to life.

Finally, it is helpful to bear in mind that all of us are subject to stressors and frustrations, that even the most fortunate men and women meet with adversity. It is wise to heed Barron's words, that health or soundness is not the absence of stress or adversity but is the way of reacting to it.<sup>31</sup>

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**Action:** Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalamic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

**Indications:** Yocon<sup>®</sup> is indicated as a sympatholytic and mydriatic. It may have activity as an aphrodisiac.

**Contraindications:** Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

**Warning:** Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

**Adverse Reactions:** Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.<sup>1,2</sup> Also dizziness, headache, skin flushing reported when used orally.<sup>1,3</sup>

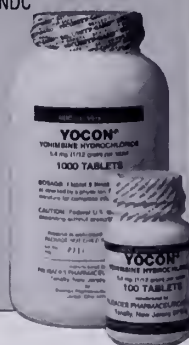
**Dosage and Administration:** Experimental dosage reported in treatment of erectile impotence.<sup>1,3,4</sup> 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to 1/2 tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.<sup>3</sup>

**How Supplied:** Oral tablets of Yocon<sup>®</sup> 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

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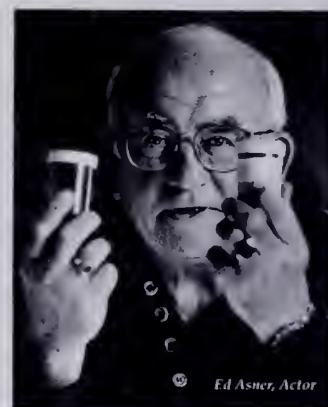
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## Attention: Physicians



Ed Asner, Actor

### Have your patients' medicines had a check-up?

Many of your patients take several different medicines every day. Separately each one works well. But if they take two or more different medicines in combination without checking with you to be sure they work safely together, they can sometimes be harmful...even dangerous.

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666 Eleventh Street, NW  
Suite 810  
Washington, DC 20001

A public service message from the National Council on Patient Information and Education (NCPIE) and the U.S. Administration on Aging

# Gazing Upon Stars and Morning Glories

**R**ecently, an unexpected bouquet of stargazer lilies arrived in radiant bloom, sent by a patient who felt something special had been done. Actually, this visual explosion of near perfect white blooms with crimson anthers had a healing effect on all who happened upon them unexpectedly in an examining room over many days. And, it was I for whom something special had been done. Moreover, they helped me to stand back and reflect upon the beauty in the most simple and basic roots of our profession.

Throughout the country physicians are dealing with the change of the face of the practice of medicine. Physicians are worried about retaining their practices as managed care infiltrates their communities. Physicians are concerned about the paraprofessionals whom capitated plans require in order to permit the volume demanded to pass through their doors under their supervision but not their direct care. New concepts emerge in our vocabularies reflecting changes and concerns in

our practices, . . . concepts such as selection, . . . and, now, DESELECTION! Clerks on the other line of the phone tell us what is appropriate care and what is not. Even the director of Human Resources sends out protocols for treatment of urinary tract infections "which must not be seen as mandatory." State-directed tax issues and society-directed "no-flaw" liability issues hover. The media have no second thoughts *before* running "drive-by" articles which demean or harm physicians' reputations and their practices with the front page judge and jury system some reporters and their editors condone. Maybe you were caught in the wrong place at the wrong moment by virtue of working long, high risk hours bent over preemies in a hospital affiliated clinic reimbursed by Medicaid. Or maybe you're a target for a front page drive-by because that perpetually angry patient, who wanders from doctor to doctor never happy in life or in a medical office, picks your name and calls a reporter.

But just when it seems as though your time is more consumed with managing these whirling masses of concerns than your patients themselves, a bouquet of refreshing flowers, or a hug from a grateful patient can return you to your originating strength and source.

Robert R. Goodin, MD, emerges on the front of medicine in Kentucky in his inaugural address with the same unexpected refreshing qualities: "This is an era of change" . . . "we're taking change to automatically be undesirable, and it's just not necessarily so" . . . the main reasons we went into medicine are all still there, despite current circumstances." "My theme for next year is pride in our profession." "Is this a great profession, or what?"

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*"Dr Goodin came bursting onto the stage of the current medical climate with a rootedness, an optimism, and a deep-felt respect for his position of trust . . . He reminds us to focus on what brought us into medicine to begin with."*

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In his address, Dr Goodin came bursting onto the stage of the current medical climate with a rootedness, an optimism, and a deep-felt respect for his position of trust. This formative attitude and enjoyment of his moments of success were uplifting. He reminds us to focus on what brought us into medicine to begin with. His is an optimistic message that brightens our walk together and strengthens our footing.

A seventeenth century Japanese poet, Basho, wrote:

*I am one  
who eats his breakfast  
gazing at the morning glories.*

We could all do with a dose of such an attitude. Hug that patient back when she looks up to you with gratitude and throws her arms around your waist. Enjoy the freshness of the message the stargazer lilies bring you, the simplicity of one of nature's small, perfect wonders. Remember the reasons we came into medicine to begin with. Enjoy the human exchange, and your ability to comfort, sometimes help, but above all do no harm.

Martha K. Heyburn, MD

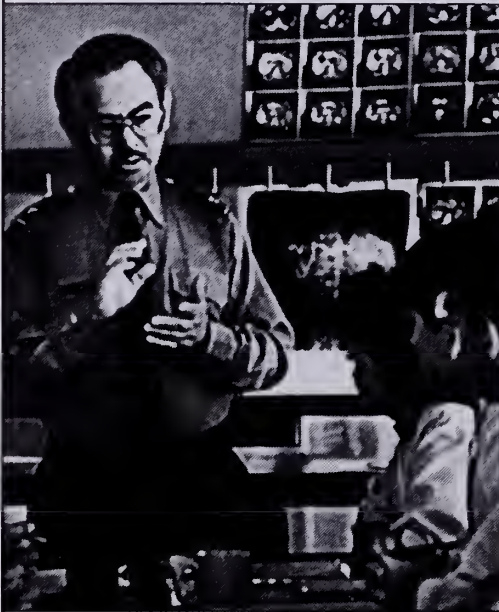
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*"Just when it seems as though your time is more consumed with managing these whirling masses of concerns than your patients themselves, a bouquet of refreshing flowers, or a hug from a grateful patient can return you to your originating strength and source."*

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## Psychiatric Symptoms in "Stable" Bipolar Outpatients

**T**O THE EDITOR: Bipolar illness is generally conceived as a disorder in which periods of mood disturbance are interdispersed among periods of asymptomatic euthymia. Yet, there is an increasing conviction among some clinicians that at least some bipolar patients are never quite stable; that is they may frequently exhibit subsyndromal symptoms (defined as some symptoms of mood disturbance that do not fulfill full DSM-III-R<sup>1</sup> criteria). This latest clinical lore may have originated due to American psychiatrists' tendency to treat bipolar patients with lower doses of lithium.<sup>2-4</sup> Recent studies have clearly shown that psychiatric subsyndromal symptoms are more prominent in individuals maintained at lower lithium levels.<sup>5,6</sup> In an effort to determine the extent of psychiatric morbidity in individuals maintained at therapeutic drug levels, we conducted a prospective evaluation of seven patients.

### Methods

Seven males with DSM-III-R<sup>1</sup> bipolar illness compliant with treatment by lithium ( $n = 6$ ), carbamazepine ( $n = 3$ ), or neuroleptics ( $n = 3$ ), were evaluated every 1 to 2 months for a mean of 19 months. All patients were compliant with their treatment and had therapeutic drug levels (for lithium  $\geq 0.7$  and  $\leq 1.2$  mEq/L). Symptoms were rated with the Psychiatry Symptom Assessment Scale (PSAS)<sup>7</sup> which quantifies mania, depression, or psychosis. Data were evaluated with student's t-test.

### Results and Discussion

Six of the seven patients experienced at least one mild affective episode in the study period. Two experienced hypomania, and five experienced mild depression, diagnosed utilizing

clinical DSM-III-R criteria. During euthymia, PSAS ratings averaged  $6.0 \pm \text{SEM } 1.41$ ; during periods of mood disturbance, mean PSAS ratings were  $16.1 \pm 2.15$  ( $p = 0.002$ ). With the exception of 17% of euthymic visits, PSAS ratings greater than 10 indicated an active mood disturbance.

These data indicate that while minor mood relapses are common in compliant bipolar patients, interepisode subsyndromal symptoms are relatively uncommon. This is compatible with previous studies comparing low and moderately high lithium levels.<sup>4,6</sup>

Rif S. El-Mallakh, MD  
Shane Iler  
Mood Disorders Research  
Program  
Department of Psychiatry  
& Behavioral Sciences  
University of Louisville  
School of Medicine  
Louisville, KY 40292

### References

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition-Revised (DSM-III-R). Washington, DC: American Psychiatric Press. 1989.
2. Cohen I, Bunney WE, Cole JO, Fieve RR, Gershon S, Prien RF. The current status of lithium therapy: Report of the APA task force. *Am J Psychiatry*. 1975;133:997.
3. Consensus Development Panel. NIMH/NIH Consensus Development Conference Statement: Mood disorders, pharmacologic prevention of recurrences. *Am J Psychiatry*. 1985;142:469.
4. El-Mallakh RS. Preventing bipolar relapse while avoiding lithium toxicity: The role of the lithium ration and intraerythrocyte lithium concentration determination. *Lithium*. 1993;5:17.
5. Gelenberg AJ, Kane JM, Keller MD, et al. Comparison of standard and low serum levels of lithium for maintenance treatment of bipolar disorder. *N Engl J Med*. 1989;321:1489.
6. Keller MB, Lavori PW, Kane JM, et al. Subsyndromal symptoms in bipolar disorder: A comparison of standard and low serum levels of lithium. *Arch Gen Psychiatry*. 1992;49:371.
7. Bigelow LB, Berthot BD. The Psychiatric Symptom Assessment Scale (PSAS). *Psychopharmacol Bull*. 1989;25:168.



## 1994

## FEBRUARY

**5-8 — The Southeastern Surgical Congress, New Orleans, LA.** Contact: R. Phillip Burns, MD, Suite 410N, 1776 Peachtree St, Atlanta, GA 30309.

**6-8 — Cardiovascular Conference at Snowshow, Mountain Lodge Conference Center, Snowshoe, W VA.** Sponsored by the American College of Cardiology. Contact: Registration Secretary, Extramural Programs Dept, American College of Cardiology, 9111 Old Georgetown Rd, Bethesda, MD 20814-1699; 800/257-4739 (outside the US and Canada, 301/897-2695); FAX 301/897-9745.

**19-24 — 26th Annual Family Medicine & Primary Care Review — Session I (3 identical sessions), Hyatt Regency Hotel, Lexington, KY.** Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

## MARCH

**8-10 — Nuclear Oncology, sponsored by Johns Hopkins Medical Institutions, Baltimore, MD.** Contact: Jeanne Ryan, Program Coordinator, Johns Hopkins Medical Institutions, Office of Continuing Education, Turner Building, 720 Rutland Ave, Baltimore, MD 21205; 410/955-2959; or Julia W. Buchanan, Course Co-director, 410/955-8582.

**17-18 — 23rd C. Dwight Townes Memorial Seminar, University of Louisville, Dept of Ophthalmology.** Contact: Nancy Rodman, 502/852-5466.

## APRIL

**7-8 — Office Endocrinology, Radisson Plaza Hotel, Lexington, KY.** Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204/6333; FAX 606/323-2008.

**22-23 — Topics in Geriatrics, Radisson Plaza Hotel, Lexington, KY.** Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204/6333; FAX 606/323-2008.

**28-May 5 — 54th Annual American Occupational Health Conference, Sands Expo and Convention Center, Las Vegas, NV.** Contact: ACOEM, 55 W Seegers Rd, Arlington Heights, IL 60005; 708/228-6850; FAX 708/228-1856.

## MAY

**12-13 — Contemporary Pediatrics for the Primary Care Physician, Hyatt Regency Hotel, Lexington, KY.** Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

**21-26 — 26th Annual Family Medicine & Primary Care Review — Session II, Hyatt Regency Hotel, Lexington, KY.** Contact: Of-

fice of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

## JUNE

**8-10 — Advanced Life Support in Obstetrics, Holiday Inn North, Lexington, KY.** Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

## JULY

**12-16 — Internal Medical Board Review, Radisson Plaza Hotel, Lexington, KY.** Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

## NOVEMBER

**5-10 — 26th Family Medicine and Primary Care Review - Session III, Hyatt Regency Hotel, Lexington, KY.** Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

**17-18 — Perinatal/Neonatal Symposium, Radisson Plaza Hotel, Lexington, KY.** Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.



TRAVEL LIGHT.

American Heart Association 

EXERCISE.

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# Hope and Opportunity

**W**ith the beginning of a new year comes hope and opportunity. Hope that some of the many problems surrounding health care in Kentucky and across the nation will be reconciled. With hope comes the many opportunities that we as Kentucky citizens and medical families will have to impact the reform of the health care system. Each of us must make our resolution of the New Year be one of commitment. The commitment to be involved in every way possible to see that with changes in the health system, we are heard. We must continue to speak out on behalf of all citizens to assure that they continue to have their constitutional right of "freedom of choice." The medical community must be united in our efforts to ensure that every citizen receives quality medical care and continues to have the right to choose their own physician.

No doubt there will be a lot of work by Congress to implement some form of health system reform this year. We need to work to see that the patient protection act is a part of any reform. There must be tort reform to help in controlling rising health care cost by preventing unwarranted

litigation. Will this year's Congress attempt huge Medicare and Medicaid cuts on top of those imposed already? How will those cuts be implemented? Will this Congress move to protect patients and physicians from the worst practices of some managed care organizations? What will the answers to these questions be? Physicians must be a part of the solution, not a recipient of the solution. Only if physicians are a part of the solution can we truly have the patient's rights represented.

Start the new year with a commitment of membership to your local, state, and national organization. Every physician and every physician's spouse needs to join. The stronger and more unified we become in numbers and in our involvements with our respective organizations, the greater our impact will be. Every physician and physician spouse must become involved with the political process.

Join with us today in our support of quality and reasonable reform for all citizens. Make membership in the Kentucky Medical Alliance and the American Medical Alliance your number one priority for 1995. Encourage others to join with you.



Become a friend of your Legislators, Senators, and Congressmen.

*Joyce Clark*

**KMA Alliance President**

If your spouse is a member of the AMA Alliance and has not been receiving its publication, *FACETS*, please contact the KMA office, 301 N Hurstbourne Pkwy, Suite 200, Louisville, KY 40222, Attn: Jean Wayne; phone 502/426-6200.

## BECOME INVOLVED TODAY TO PROTECT THE FUTURE OF TOMORROW

To join the Kentucky Medical Association Alliance fill out and return the form below with your check for \$40.00, made payable to KMAA. Mail to: Jean Wayne, KMAA, 301 N Hurstbourne Pkwy, #200, Louisville, KY 40222-8512.

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## PEOPLE

**William H. Mitchell, MD**, Richmond, was named 1994 Kentucky Physician of the Year by the Kentucky Medical Review Organization. The award was established in 1990 to recognize physicians for outstanding contributions to the peer review process and organization. Dr Mitchell was recognized for his many contributions while serving as Chairman of the Sanction Committee for Kentucky and as a physician reviewer.

**Herbert A. Lassiter, MD**, recently spent a month as a visiting scholar in the department of neurology at the University of Cambridge Clinical School in Cambridge, England. Dr Lassiter, an associate professor of pediatrics at the University of Louisville School of Medicine, now can culture the cells which produce white matter in the brain. At U of L, the technique will be used to develop a new treatment to prevent brain damage in newborn babies.

**Beverly Gaines, MD**, a pediatrician, volunteer, and community leader, recently received the third annual Communicator of the Year Award, presented at the 12th annual Landmarks of Excellence Awards program.

The award recognizes an individual whose communication skills in the past year have had a positive influence on the community. Dr Gaines has served on the Governor's Task Force on Health Care Access and Affordability and was appointed to the first Kentucky Health Policy Board. She organized the African American Health Jamboree involving seven community sponsors and more than 60 exhibitors.

The awards are co-sponsored by the local chapters of the International Association of Business Communicators and the Public Relations Society of America and

recognize achievement in public relations and business communications in Kentucky and Southern Indiana.

The following KMA member physicians were included in recent faculty promotions at the University of Louisville: **Martin S. Blumenreich**, medicine, professor; **Mary H. Davis**, psychiatry and behavioral sciences, associate professor; **E. Nigel Harris**, medicine, professor; **Tsung-Yao Huang**, diagnostic radiology, professor; **Betty W. Joyce**, pulmonary medicine, assistant professor; **Herbert A. Lassiter**, pediatrics, obstetrics and gynecology, associate professor; **Gary S. Marshall**, pediatrics, associate professor; **Alvin W. Martin**, pathology, associate professor.

Continuing the list were **Charles R. Prince**, medicine, associate professor; **Joseph A. Spinnato**, obstetrics and gynecology, professor; **Dan L. Stewart**, pediatrics, associate professor; **Daniel M. Sullivan**, medicine, associate professor; **Sonia R. Teller**, medicine, associate professor; **Barry H. Miller**, anesthesiology, assistant professor; **Michael Sagatelian**, medicine, assistant professor; and **William S. Smock**, emergency medicine, assistant professor.

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## UPDATES

### Cardiomyoplasty at U of L

Two U of L surgeons have wrapped a man's back muscle around his ailing heart to help it function more normally.

The procedure, called cardiomyoplasty, was performed by **David Slater, MD**, and **Gordon Tobin, MD**, of the department of surgery.

U of L is the sixth of 11 centers nationwide to gain permission from the Food and Drug Administration (FDA) to perform the experimental procedure.

The 9-hour operation involved two stages, explained Slater, and will involve a long period of muscle "training."

In the first phase, the latissimus dorsi, a muscle attached along the back and the pelvis which then extends up to the armpit, is separated from pelvic and back moorings.

Wires connected to a new stimulator that will shock the muscle into action are attached to the nerve tissue, and then the muscle is pushed through an incision into the chest cavity.

During the second stage, the muscle end that had been attached at the arm is secured to the chest wall and the muscle drawn into the chest cavity and wrapped around the heart. The electronic stimulator is placed in a pocket created in the abdominal wall.

Surgery, however, is only half of the procedure, said Slater. The other half involves training the back muscle to contract with the heart, and strongly enough to be of help.

That takes time.

Every two weeks, electrical stimulation is increased until the wrapped muscle begins to contract in such a way that it aids the heart's function. By eight to 12 weeks, the muscle is fully trained.

According to the report, the procedure presents several important advantages for victims of heart disease. First, since the patient's own muscle is used, organ rejection is not a factor, and antirejection drugs which suppress the patient's immune system are unnecessary.

The procedure is not, however, a substitute for a heart transplant, Dr Slater added, because it takes so long after surgery for the treatment to be of help.

## NEW MEMBERS

*Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.*

## Adair

**Maria de Jesus Baltierra, MD — GP**  
PO Box 560, Russell Springs 42642  
1981, U of Minnesota

## Allen

**Lee Del Carter, MD — GP**  
17 W Main St, Scottsville 42164  
1975, Loma Linda U

## Boyd

**George K. Aitken, MD — ORS**  
2301 Lexington #215, Ashland 41101  
1980, U of Toronto

## Bell

**C. Edward Yee, MD — OPH**  
13 Cherokee Dr, Middlesboro 40965  
1989, Creighton

## Boyle

**John M. Horn, MD — IM**  
159 M L King Blvd, Danville 40422  
1984, U of Arkansas

## Christian

**Gilbert Brandon, Jr, MD — OTO**  
1717 High St #2C, Hopkinsville 42240  
1981, U of Tennessee

## Clark

**August J. Ott, III, MD — IM**  
1109 McCann Dr, Winchester 40391  
1985, U of Kentucky

## Cayette

**Jeffrey P. Campbell, MD — PS**  
3900 Crosby Dr, Lexington 40515  
1988, U of North Carolina

**Eric R. Holz, MD — C**  
120 N Eagle Creek, #S-500, Lexington 40509  
1989, Baylor

**Kenneth V. Hughes, III, MD — OTO**

1760 Nicholasville Rd #602, Lexington 40503

1989, U of Oklahoma

**James W. Matthews, MD — OPH**  
1401 Harrodsburg Rd #A210,  
Lexington 40504

1982, Marshall U

**John M. O'Brien, MD — OBG**  
2109 Woodley Cir, Lexington 40502  
1988, Wayne State

**Susan K. Samlaska, MD — AN**  
280 Stone Rd, Lexington 40503  
1989, Marquette

**Walter A. Shank, Jr, MD — IM**  
4213 Palmetto Dr, Lexington 40513  
1991, U of Southern Florida

**Scott A. Riley, MD — ORS**  
1725 Harrodsburg Rd #C, Lexington 40504

1983, Case Western

## Greenup

**David K. Bush, MD — C**  
800 St. Christopher Dr, Ashland 41101  
1988, U of Louisville

## Jefferson

**Robert L. Long, Jr, MD — U**  
210 E Gray St #1000, Louisville 40202  
1975, U of Kentucky

**Mark W. Distler, MD — PD**  
1701 Spring St, Jeffersonville, IN 47130  
1991, U of Louisville

## Johnson

**Charles E. Hardin, Jr, MD — FP**  
PO Box 88, Salyersville 41465  
1982, U of Kentucky

## Knox

**David A. Worthy, MD — FP**  
215 N Allison Ave, Barbourville 40906  
1987, Oral Roberts U

## Lawrence

**Lee A. Balaklaw, MD — AN**  
1057 Meadowbrook Ln, Louisa 41230  
1980, Far Eastern U

## Laurel

**Alvin D. Perkins, MD — PTH**  
1531 W Pine Hill Rd, London 40741  
1985, Medical Col of Ohio

## Mason

**David L. Blandford, MD — OPH**  
109 E Third St, Maysville 41056  
1989, U of Kentucky

**Roger C. Gustafson, MD — OBG**  
1350 Medical Park Dr, Maysville 41056  
1965, U of Saskatchewan

## McCracken

**Daniel M. Tkach, MD — PS**  
4411 Westchester Ln, Paducah 42003  
1986, U of Oklahoma

## Montgomery

**Brian D. Williams, MD — OBG**  
15 Sterling Ave, Mount Sterling 40353  
1982, Marshall U

## Nelson

**Robert F. Huxol, DO — EM**  
3675 Louisville Rd, Bardstown 40004  
1975, Michigan State

## Northern Kentucky

**Denise M. Perone-Carabella, MD — P**  
1060 Nimitz View Dr ZC, Cincinnati, OH 45230  
1978, U of Cincinnati

**Mark A. Schroer, MD — IM**  
17 E 6th St, Newport 41071  
1991, U of Louisville

## Perry

**Ronald K. Belhasen, MD — ORS**  
200 Medical Ctr Dr #1S, Hazard 41701  
1986, U of Kentucky

## Pulaski

**Eduardo R. Gomez, MD — R**  
PO Box 3371, Somerset 42501  
1981, Loyola

## Shelby

**Karen E. Reed, MD — OBG**  
720 Hospital Dr #112, Shelbyville 40065  
1989, U of Kentucky

## Warren

**Thomas E. Moeser, MD — OBG**  
825 4th St, Bowling Green 42101  
1970, George Washington U



**Washington**

**Julia Keeling Brown, MD** — IM  
219 W Main St, Springfield 40069  
1991, U of Kentucky

**In-Training****Jefferson**

**Timothy A. Feger, MD** — PD  
**Eduardo W. Quesada, MD** — AN

**Northern Kentucky**  
**Kevin L. McChord, MD** — FP

**Robert B. Warfield, MD**  
**Lexington**  
**1907-1994**

Robert B. Warfield, MD, a retired pediatrician, died October 22, 1994. A 1933 graduate of Jefferson Medical College of Thomas Jefferson, Philadelphia, PA, he was a life member of KMA.

**Thomas G. Day, Jr, MD**  
**Louisville**  
**1942-1994**

Thomas G. Day, Jr, MD, a gynecological oncologist, died November 7, 1994. Dr Day was a 1967 graduate of the Medical College of Virginia, Commonwealth University, and was an active member of KMA.

**DEATHS**

**William L. Heizer, MD**  
**Lexington**  
**1908-1994**

William L. Heizer, MD, a retired general practitioner, died September 1, 1994. A 1933 graduate of the University of Michigan Medical School, Dr Heizer was a life member of KMA.

**Ray A. Cave, MD**  
**Leitchfield**  
**1907-1994**

Ray A. Cave, MD, a family practitioner, died September 15, 1994. Dr Cave was recognized with a special memorial tribute in the form of a Resolution by the 1994 KMA House of Delegates at its Annual Meeting held September 19-22. He was scheduled to be honored on September 23, 1994, by the Health Care Access Foundation for treating more indigent patients free of charge than any other physician in Kentucky, while participating in the Kentucky Physicians Care Program. Dr Cave was a 1960 graduate of the University of Louisville School of Medicine and had been a member of KMA since 1964.

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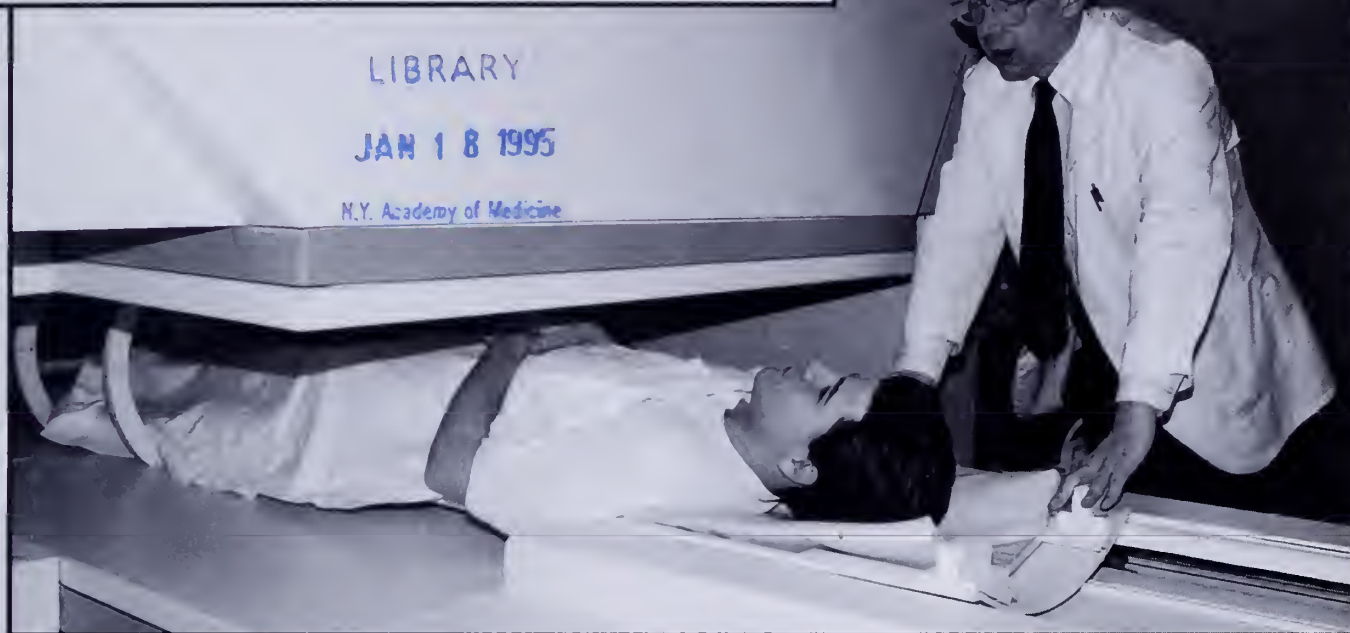
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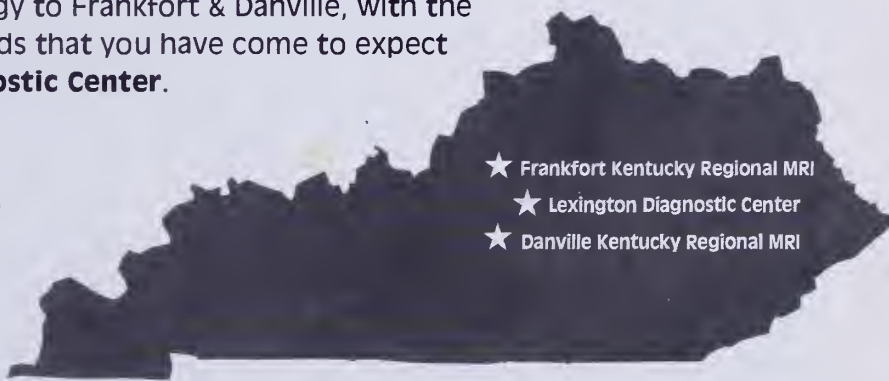
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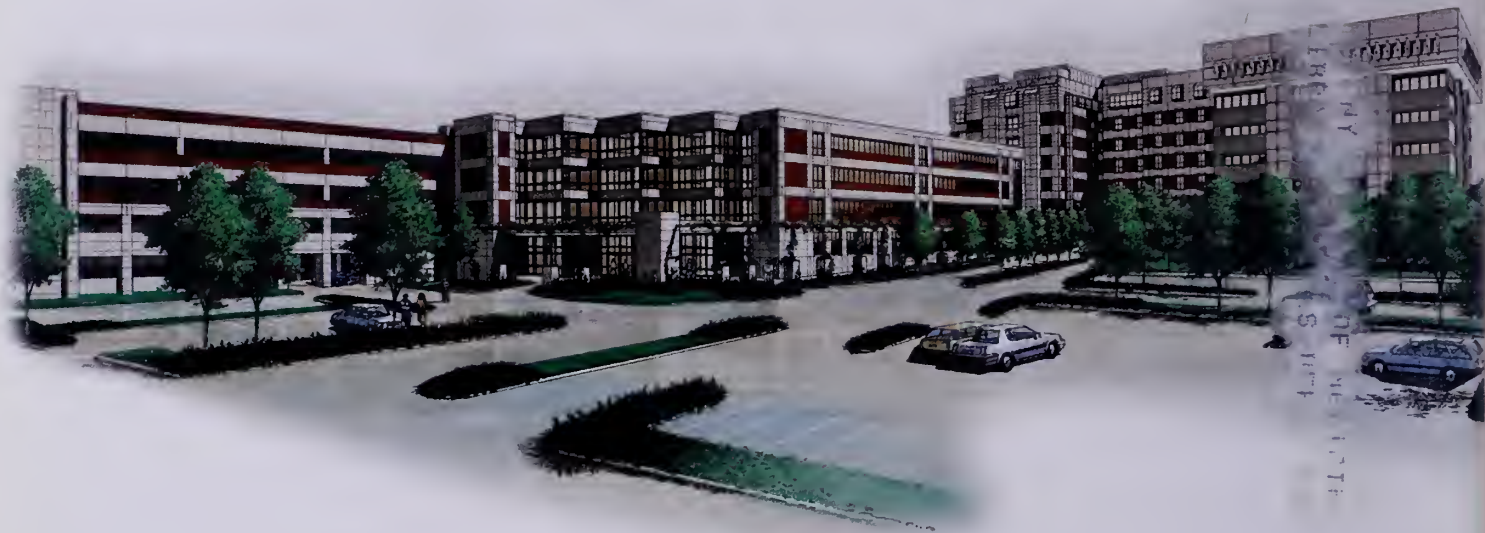
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FEBRUARY 1995  
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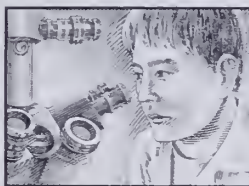
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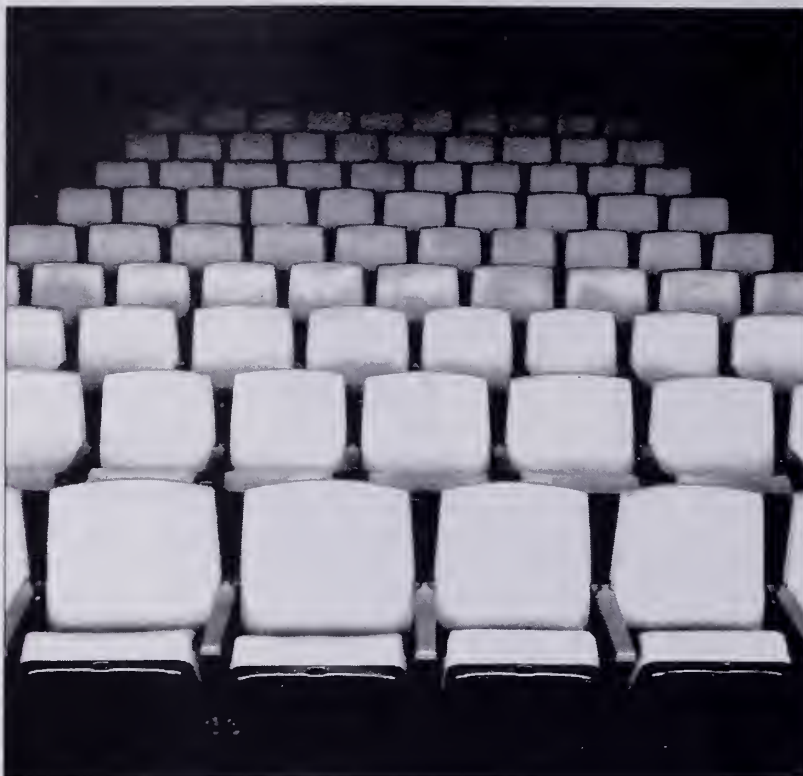


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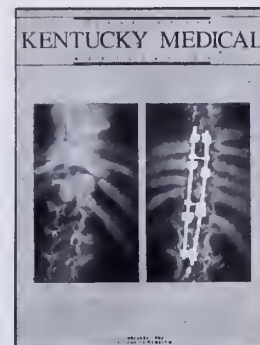
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VOLUME 93, NUMBER 2

FEBRUARY 1995



**COVER:** Clinical and radiographic aspects of neuropathic spinal orthopathy are described and a case history depicted in our cover story beginning on page 48. Cover art by Lee Wade of Louisville.

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# Involvement — A Must

**T**his is the first chance I have had to thank you for giving me the opportunity to serve as your President-Elect for this Association year. I have been very fortunate to have worked with outstanding physicians who have held this office and hope that I can do as much for organized medicine as they have.

We must all get involved. Medicine today requires much more than caring for and about our patients. We have to be their advocate and help guide them through the maze medical care has become.

We must be involved in our own communities. The more we help others outside our practice, the more people we can talk to about what medicine really is. We must take time to talk to our patients and friends about the changes occurring in medicine; what they mean to us and what we think the future holds for our patients. Even though we are all busy, we must try to see to it that others understand our feelings about these changes.

We must be involved with organized medicine. When we work together, we can accomplish a great deal. Changes are sometimes much slower than we would desire, but your officers and staff are trying diligently to serve you, and they deserve and need your full support.

We must be involved politically. Kentucky politicians have learned that physicians can influence elections. We must find candidates we can support and work for them. As this is being written, Dr James Crase of

Somerset is a candidate for state senator in a special election on December 27. He is willing to give up a great deal of his time in order to serve the Commonwealth, and his peers have agreed to help him with his practice so that he can do this. We must all be ready to support other physicians who are willing to run for public office and help them care for their practice as much as possible at the same time. None of us in KMA leadership would be able to do this without the support and assistance of our colleagues at home who cover for us. I, personally, am extremely grateful to the Cumberland Womens' Group of Somerset. Without such assistance, no one, especially in a solo practice, would be able to be actively involved in organized medicine.

Encourage your spouse to become involved with the Alliance. If your county does not have an active alliance, encourage your spouses to form one. Having watched my wife serve as President of the Alliance for the last year, I can assure you that it is a very vital and active organization that can be a great source of help for medicine both in the community and politically.

When all is said and done, we cannot escape the changes that are occurring in medicine. In order to survive and care for our patients, we must all become actively involved in all aspects of medical care.

**Danny M. Clark, MD**  
KMA President-Elect



*Danny M. Clark, MD*

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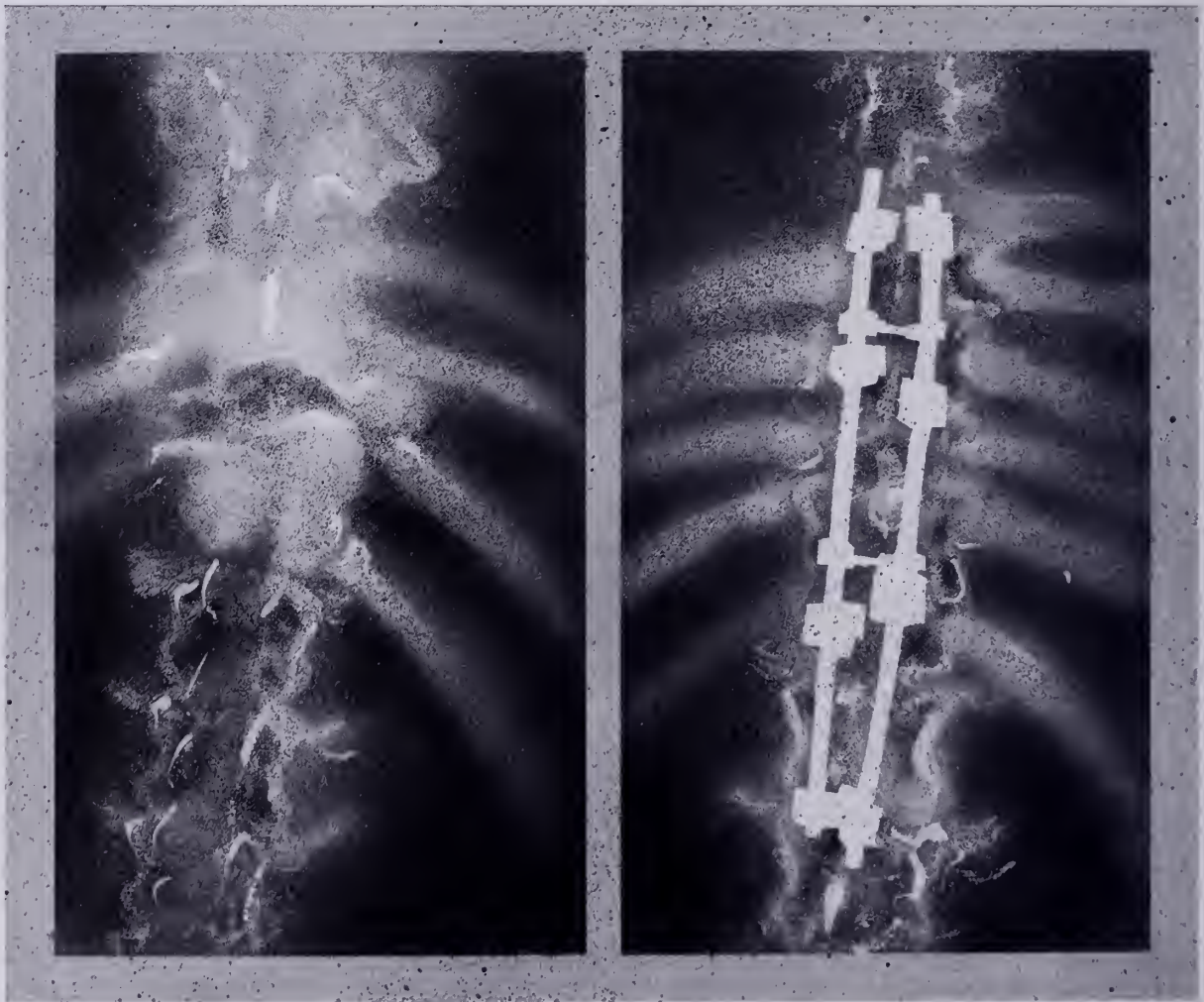
***"Medicine today requires much more than caring for and about our patients. We have to be their advocate and help guide them through the maze medical care has become."***

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# Neuropathic Spinal Arthropathy: A Case History and Six Year Follow-up

*Joseph G. Werner, Jr, MD; Richard T. Holt, MD*



*Neuropathic spinal arthropathy is a rare but well-reported sequela of tabes dorsalis. It is now more frequently seen as a complication of spinal cord injury — particularly after spinal fusion. With improved longevity of spinal cord injured patients we are seeing this entity in increased frequency.*

*Clinical and radiographic aspects are described, and a case history is depicted. Classic treatment has been conservative. Based on the changing nature of its etiology and favorable reports from large centers we advocate anterior and posterior fusion and instrumentation of Charcot's Spine.*

The patient, a 55-year-old white male, has been a quadriplegic since a diving accident at age 15. Thirty years following the accident, he began experiencing local thoracic back pain and difficulty with "sinking" into his wheelchair. Examination revealed a low thoracic palpable clunk and overlying decubitus ulcer. Figs 1 and 2 demonstrate the classic ball-and-socket giant pseudoarthrosis.

A plastic surgeon was consulted and excision of the decubitus ulcer and infected bursa was performed with primary closure. Six weeks later, anterior T11 resection, debridement, and iliac crest strut grafting were performed. Posterior spinal fusion with iliac crest bone grafting and Cotrel-Dubousset (CD) instrumentation from T9 to L2 was completed at the same setting (Figs 3, 4). Estimated blood loss was 1800 cc. Cultures were negative.

Aftercare consisted of a short period of inpatient rehabilitation. An oyster shell brace was worn for 12 months. A superficial back wound infection was treated locally and healed without event. He returned to his duties as a university professor 2 months postoperatively. Radiographs confirm long-term maintenance of reduction and integrity of the fusion mass and hardware (Figs 5, 6). At 6 year follow-up the patient reports continued relief of pain and instability.

## Discussion

Neuropathic arthropathy is mechanical joint degeneration that occurs as a result of impaired deep sensation to the joint. Though initially described by Mitchell,<sup>11</sup> this is attributed to Charcot who wrote of its association with tabes dorsalis in 1868.<sup>2</sup> Kronig in 1884 was the first to describe its manifestation in the spinal column.<sup>8</sup>



**Figs 1 and 2 — A classic Charcot spine at T11 -T12.**

*Dr Halt is affiliated with Spine Surgery, PSC, 210 E Gray St, Suite 601, Louisville, KY 40202, and Dr Werner is with the Kentucky Spine Institute, 135 E Maxwell, Suite 208, Lexington, KY 40508.*



## Neuropathic Spinal Arthropathy



**Figs 3 and 4 — Anterior and posterior fusion maintained by CD instrumentation from T9 -L2.**



**Figs 5 and 6 — At 6 year follow-up the fusion mass is maintained and the hardware is intact.**

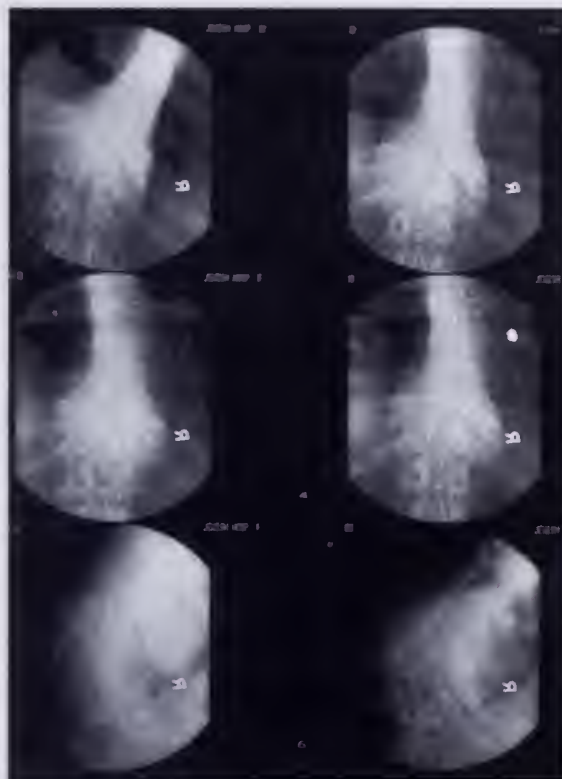
Today, spinal neuropathic arthropathy is more commonly encountered as a sequela of spinal cord injury.<sup>3,4,10,12</sup> Fusions and laminectomies seem to act as stress risers to increase its incidence in this population. Rare reports describe its occurrence in myelodysplasias, diabetics, tumor patients, and patients with congenital insensitivity to pain.<sup>9,10</sup> These etiologies suggest an injury to afferent proprioception which can occur in fibers ranging from peripheral nerve to the dorsal column. These proprioceptive deficits in conjunction with ongoing motor function contribute to a cycle of joint trauma and effusion, ligamentous laxity, micro fractures, traumatic arthritis, and ultimate bony destruction. This entity was originally described as occurring in 3% to 10% of tabetic patients according to Steindler.<sup>13</sup> The spine is the third most commonly involved joint in tabes dorsalis.<sup>13</sup> Neuropathic arthropathy is now seen most commonly in spinal cord injured patients with an incidence of less than 1%.<sup>10</sup>

### Clinical Features

In many studies the most common presenting complaint is back pain.<sup>4,10,12</sup> This stands in contradistinction to classically taught theory concerning the Charcot joint.<sup>7</sup> Kyphotic deformity is a quite common complaint as is abnormal spinal motion. The patient may describe loss of sitting balance, particularly those who are wheelchair bound. Cauda equina syndrome and loss of sitting height are occasional presenting complaints. A history of sexually transmitted diseases should be obtained. Presence of fever or weight loss is likewise important. A complete neurologic review of systems should be obtained.

On physical examination the region may be tender to palpation. Kyphosis or lateral angular deformity is frequently present, particularly in the unstable pseudoarthrosis. A "clunk" may be heard or palpated as this instability is manifested on examination. Decubitus ulceration is not infrequent over the site of prominence in kyphotic involvement. It can present with paraplegia or even as an incidental radiographic finding.

Two main types of pseudoarthroses are seen: a localized atrophic pseudoarthrosis which is rare in occurrence, as well as a diffuse hypertrophic presentation.<sup>5</sup> The hypertrophic appearance involves a loss of disc space height, bony sclerosis, osteophyte formation, marginal fractures, and paravertebral ossification. Occasionally bony ankylosis is noted, but more frequently seen is the



**Fig 7 — Extensive instability of the pseudoarthrosis is demonstrated by serial fluorographs.**

ball-and-socket giant pseudoarthrosis. Fig 7 shows the fluoroscopic radiographs of a patient with a giant ball-and-socket pseudoarthrosis and demonstrates the extent of instability which is often present in these.

Nuclear scans may be obtained but are usually unnecessary. Technetium scans are nearly always positive whereas gallium scan results are equivocal.<sup>4</sup> Indium scans are typically negative with Charcot spinal arthropathy. CT scanning and MRI are reserved to rule out differential diagnoses.

Though biopsy is seldom indicated, pathological specimens typically show grossly distorted vertebral endplates with extensive microfractures and considerable fibrous tissue interposed in the pseudoarthrosis site. Extensive granulation tissue may be found in the intervening space.

Differential diagnosis includes infection and in particular, tuberculosis. Osteoarthritis, tumor, and Padgett's disease may all masquerade in rare instances as a Charcot joint.

Treatment is immobilization. In the past this has been manifested as a nonoperative treat-



## Neuropathic Spinal Arthropathy

ment.<sup>6,12</sup> Other options include instrumented and uninstrumented operative fusion.<sup>1,3,4,10</sup>

Conservative treatment in the past has included bed rest, casting, and orthotics.<sup>6,12</sup> These methods appear more suited to the tabetic population in which scant reports exist of limited success in its treatment. They appear poorly adapted to spinal cord injured patients, however, and it is in this population which we now more frequently see Charcot joint.<sup>3,4,10,12</sup> Skin ulceration and pulmonary complications can occur as a result of these immobilization techniques in patients with sensory deficits secondary to spinal cord injury.

Operative non-instrumented fusion has been tried<sup>1,3</sup> — results appear to be similar to non-operative care. Nonunion is frequent. Persistent pain is an issue which is not addressed in these reports. Similarly unsuccessful results have been obtained from nonsegmental instrumentation, ie, Harrington instrumentation, in these unstable lesions.

With the advent of segmental spinal instrumentation considerable inroads have been made in achieving improved stability in these inherently unstable pseudoarthroses. Anterior strut grafting can provide additional biomechanical advantage to stability. McBride and Greenberg describe four cases in which staged anterior and posterior fusion with CD instrumentation were performed.<sup>10</sup> Three of four cases healed with correction of kyphosis and one of four developed a pseudoarthrosis with loosening of the lower hooks. This was later revised with a successful fusion. Devlin and Bradford in 1991 described 10 cases of segmentally instrumented spines some of which were anteriorly augmented.<sup>4</sup> Eight of 10 resulted in fusions with a total of nine complications occurring in five patients. These included instrumentation failure, infection, persistent pseudoarthrosis, and graft dislodgment. In each case, however, the patient was ultimately improved. Their conclusion was that posterior segmental instrumentation and fusion was indicated for single level involvement. Anterior augmentation was recommended for multi-level or kyphotic involvement. The additional recommendation was made that no intercurrent unfused segments remain.

## Conclusion

Improvements in medical care have resulted in reduced incidence of tertiary syphilis and increased longevity of spinal cord injury patients. This has changed the etiology of Charcot spinal arthropathy. Prior methods of treatment appear especially unsuccessful in this new population. Prospective trials are unlikely in the near future. On the basis of remote and recent retrospective reviews as well as our own limited experience, we recommend anterior and posterior fusion with instrumentation for Charcot spinal arthropathy. Given the unstable nature of this deformity, its high propensity for kyphotic angulation, and frequency of nonunion, we believe even single level involvement should be fused both anteriorly and posteriorly.

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# Clinical Significance of Mycobacterium Other Than Tuberculosis Isolated From Respiratory Specimens at a University Hospital

Sunket Ahkee, MD; Latha Srinath, MD; Anna K. Huang, MD; Julio A. Ramirez, MD

**BACKGROUND:** *Mycobacteria other than tuberculosis (MOTT)* are ubiquitous and have been recognized to cause pulmonary disease. Because of newer laboratory diagnostic techniques, it has become more frequent to identify MOTT from pulmonary specimens. The objective of this study was to determine the spectrum of MOTT in pulmonary specimens in hospitalized patients and determine their clinical significance.

**METHODS:** A retrospective study of all cases of positive pulmonary specimens cultured for MOTT in patients admitted to University of Louisville Hospital from January 1989 to December 1992 was performed. A determination of whether or not the MOTT caused pulmonary disease was made, using the criteria required by the American Thoracic Society.

**RESULTS:** There were 221 positive pulmonary specimen cultures for mycobacteria, of which 164 were MOTT and 57 were *M tuberculosis*. Of the MOTT isolates, 82 (50%) were *M gordonae*; 44 (27%) *M avium intracellulare*; 18 (11%) *M chelonae*; 12 (7%) *M fortuitum*; 2 (1%) *M kansasii*; 2 (1%) *M scrofulaceum*; 2 (1%) *M xenopi*; and 2 (1%) *M terrae*. From all the MOTT cases, only one met the criteria for MOTT pulmonary disease. The rest were found to be non-pathogens, either colonizers or contaminants.

**CONCLUSION:** Newer laboratory diagnostic techniques are improving isolation and identification of MOTT. Even though reports of positive pulmonary specimens for MOTT are becoming more numerous, MOTT was found to be a rare pulmonary pathogen in our hospital, when strict criteria were used.

Since the discovery of the tubercle bacillus by Robert Koch in 1882, many other species of mycobacteria other than tuberculosis (MOTT) have been identified. In 1954 Timpe and Runyon provided a classification of MOTT according to their pigment production and growth characteristics. MOTT are ubiquitous and their pathogenetic role in human disease has been recognized. Recently, there has been an increasing number of case reports of pulmonary disease caused by MOTT in the literature, especially in immunosuppressed patients.<sup>1,2,3</sup> Because of newer laboratory diagnostic techniques such as DNA probes, it has become more routine to isolate and speciate MOTT from pulmonary specimens. Those isolates may be pathogenic, requiring treatment, or may represent colonization or contamination. As a result, the clinician increasingly faces the dilemma of interpreting the significance of a positive culture for MOTT. The objective of this study was to determine the spectrum of MOTT in pulmonary specimens in hospitalized patients and determine their clinical significance.

## Material and Methods

A retrospective study of all cases of positive pulmonary specimens (sputum, bronchoalveolar lavage, pleural fluid) cultured for mycobacteria in patients admitted to University of Louisville Hospital from January 1989 to December 1992 was performed. From chart review, a determination of whether or not the mycobacteria caused pulmonary disease was made. Contrary to tuberculosis where any positive sputum culture means disease, the criteria for MOTT pulmonary disease

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were more strict, following the requirements adopted by the American Thoracic Society.<sup>4</sup> A definite diagnosis of pulmonary disease caused by MOTT was based upon evidence of pulmonary infiltrate on chest x-ray and either isolation of multiple colonies of the same strain of mycobacteria repeatedly, or isolation of the mycobacteria from a normally sterile site.

### Results

From December 1989 to January 1992, there were 221 positive pulmonary specimen cultures for mycobacteria, of which 164 were MOTT and 57 were *M tuberculosis*. Of the MOTT isolates, 82 (50%) were *M gordonae*; 44 (27%) *M avium intracellulare*; 18 (11%) *M chelonae*; 12 (7%) *M fortuitum*; 2 (1%) *M kansasii*; 2 (1%) *M scrofulaceum*; 2 (1%) *M xenopi*; and 2 (1%) *M terrae*.

From all the MOTT cases, only one met the criteria of the American Thoracic Society for MOTT pulmonary disease. The rest were found to be non-pathogens: either colonizers or contaminants. The one case of MOTT causing pulmonary disease was a 54-year-old alcoholic male who was admitted with a 3-day history of hemoptysis and low grade fever. Chest x-ray revealed a cavitory lesion in the right upper lobe. Sputum smear was positive for acid fast bacilli (AFB) and six different sputum specimens collected over a 3-week period grew *M avium* complex. Blood cultures and bone marrow culture were negative for bacteria and AFB. HIV test was negative. Patient was treated successfully with a combination of clarithromycin, clofazimine, and ciprofloxacin.

### Discussion

There are many reports of pulmonary disease caused by MOTT in the literature. Pulmonary disease from MOTT has a wide spectrum of clinical presentations from simple pneumonic infiltrate to progressive destructive disease. The majority of patients with MOTT pulmonary disease have chronic underlying lung disease such as pneumoconiosis, bronchiectasis, chronic bronchitis, and emphysema. The most common pulmonary pathogens are *M avium* complex and *M kansasii*.<sup>1,2</sup> In this study, the only case of MOTT pulmonary disease was caused by *M avium* complex.

*M gordonae* was isolated in 50% of the MOTT in this study. *M gordonae* very rarely causes disease and is an unlikely colonizer of the airway.<sup>5</sup> The 82 cases of *M gordonae* seen during the study

period were found to be related to laboratory contamination of the respiratory specimens.

*M avium* complex was isolated in 27% and it caused the only case of MOTT pulmonary disease in this study. *M avium* complex is mostly either a pathogen or a colonizer and only rarely is it a contaminant. In non-HIV patients as in the case presented, *M avium* complex causes mostly pulmonary disease. In HIV infected patients, it causes disseminated disease with weight loss, fever, night sweats, abdominal pain, and malabsorptive syndrome, due to multiorgan infection.<sup>3</sup>

*M chelonae* and *M fortuitum* were isolated in 11% and 7% of specimens respectively. They belong to Runyon group IV of "rapid growers" and are mostly laboratory contaminants. In contrast to patients with *M avium* complex and *M kansasii* lung disease, the majority of patients with rapidly growing mycobacterial disease are female nonsmokers without underlying pulmonary disease.<sup>6</sup> The infiltrates on chest x-ray are mainly interstitial and reticulonodular.

*M kansasii*, *M scrofulaceum*, *M xenopi*, and *M terrae* were rarely isolated in our study, accounting for 1% each. *M kansasii* is more commonly a pathogen or colonizer and rarely a contaminant. It produces chronic lung disease similar to tuberculosis in patients with COPD or pneumoconiosis and is associated with antecedent pneumothorax in more than one third of the patients. *M scrofulaceum* is commonly a contaminant and colonizer and rarely a respiratory pathogen. It resembles *M avium intracellulare* biochemically and antigenically. It is mainly known to cause lymphadenitis in children, with a characteristic single or cluster of nodes in the submandibular area. *M xenopi* is a rare respiratory pathogen that may cause lung disease resembling tuberculosis. It is classified in the same group as *M avium* because of its antigenic characteristics and its virulence to birds.<sup>7</sup> *M terrae* is more commonly a contaminant than a pulmonary pathogen. It has been reported to cause tenosynovitis.<sup>8</sup>

None of the MOTT are transmissible among humans. Unlike patients with tuberculosis, patients with MOTT pulmonary disease do not require respiratory isolation. In patients admitted with pulmonary disease and with sputum smears positive for AFB, a presumptive diagnosis of pulmonary tuberculosis should be entertained. Isolation measures and antituberculosis therapy are pursued until culture and identification of the mycobacterium are reported. The increased reports of MOTT in pulmonary specimens have

caused unnecessary use of respiratory isolation and empiric antituberculous therapy.

When the laboratory identifies a MOTT in a pulmonary specimen, strict criteria should be applied before considering the MOTT as a pathogen. This study shows that less than 1% of all the MOTT isolated from respiratory specimens in our institution are pulmonary pathogens.

## Conclusion

The pathogenic role of MOTT in human pulmonary disease has long been recognized. Newer laboratory diagnostic techniques are improving isolation and specific identification of MOTT. Even though reports of positive pulmonary specimens for MOTT are becoming more numerous, MOTT was found to be a rare pulmonary pathogen in our hospital, when strict criteria were used.

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# An Alternate Method for Intercostal Blockade for the Management of Post Herpetic Neuralgia

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**P**ost herpetic neuralgia can be difficult to treat. In addition to antidepressants, anticonvulsants, and phenothiazines, somatic nerve blocks may be effective in the management of this painful entity.<sup>1</sup> The following case report describes the utilization of an alternate method of intercostal blockade in a patient with oxygen-dependent chronic obstructive pulmonary disease suffering from post herpetic neuralgia.

## Case Report

A 70-year-old female was referred with a chief complaint of post herpetic neuralgia affecting part of the intercostal nerve distribution in her right side. The patient reported the acute onset of severe pain (a verbal Assessment Score of 10/10; 0 = no pain and 10 = the worst pain ever experienced) 6 months prior to consultation and reported a vesicular rash in the vicinity of intercostal nerves 7, 8, 9 and 10 on her right side. She reported that the vesicles healed within 7 to 10 days. However, the pain persisted, was constant, and would range in severity from 7 to 10/10. She furthermore presented with a history of loss of appetite and difficulty sleeping. Her past medical history indicated that she had a varicella-herpes infection as a child. She had a history of severe oxygen dependent chronic obstructive pulmonary disease and asthma. She had smoked a pack of filtered cigarettes for approximately 48 years. Her medications consisted of the following: theophylline 300 mg po q 12 hrs; prednisone 10 mg po qd; metaproterenol sulfate inhaler prn and propoxyphene napsylate 100 mg with acetaminophen 650 mg po q 4 hrs prn pain.

Physical examination revealed a 62 kg, 160 cm female who when examined appeared to be in moderate discomfort. Her vital signs were as follows: blood pressure 130/80 in the right upper

extremity, pulse 112 beats/minute, and a respiratory rate of 20 breaths/minute. She was afebrile. Bilateral inspiratory and expiratory wheezes were noted to auscultation about both lung fields. Healed depigmented skin lesions were noted in the posterior regions of thoracic vertebrae 7-9 approximately two cm to the right of midline. The skin lesions extended anteriorly along the intercostal nerve distribution three to four cm anterior to the right anterior midaxillary line. Allodynia was appreciated when the skin over the healed lesions was touched.

Amitriptyline 10 mg hs was initiated along with carbamazepine, 100 mg po bid. The patient returned in 1 week for follow-up examination. There was no change in her subjective pain score. Consideration was given at that time to intercostal nerve block. A nerve block with a needle and syringe is the traditional method of performing intercostal nerve blockade. However, a factor of concern was iatrogenically causing a pneumothorax (a complication of intercostal blockade with a needle and syringe) in a patient with severe pulmonary disease. A decision was made to perform intercostal neural blockade using a needleless jet injector device (Med E Jet, Inc, Cleveland, OH) containing a local anesthetic. Informed consent was obtained from the patient to do the nerve block. The patient received intercostal neural blockade at the 7th, 8th, 9th and 10th intercostal nerves using one ml of 0.75% bupivacaine with 1/200,000 epinephrine per intercostal nerve for a total volume of five ml. A venous plasma bupivacaine sample was obtained 15 minutes post block. After 30 minutes the patient reported a post block pain score of 2/10. The patient exhibited anesthesia to pinprick in the distribution of the intercostal nerves previously described. Post block radiographs revealed no pneumothorax.

The patient's amitriptyline dose was increased to 25 mg po hs after it was determined by psychological consultation with subsequent psychological testing that she was suffering from depression related to her pain. She was also started on fluphenazine hydrochloride, one mg qd. She returned in 1 week with a pain score of 3/10. The same intercostal nerves were injected with the same volume and concentration of bupivacaine with epinephrine using the jet injector as previously mentioned. Radiographs were repeated and a venous bupivacaine plasma sample was obtained 15 minutes post intercostal block. She reported a post block pain score of 0/10, 30 minutes post block and had anesthesia to pinprick in the intercostal distribution of the intercostal nerves blocked. The patient returned 1 week later with a pain score of 0/0. Her amitriptyline and fluphenazine were continued at the same dosage for 1 month and were gradually tapered and eventually discontinued over the following 2 weeks. The plasma bupivacaine levels following the intercostal nerve blocks were 0.09 and 0.07 mcg/ml (toxic levels are 3-5 mcg/ml) respectively. Monthly follow-up by telephone indicated that the patient remained pain free at 6 months.

## Discussion

Varicella zoster virus, a host-specific DNA virus, may infect dorsal nerve roots during the primary infectious phase. Subsequently, the virus usually remains dormant unless it becomes reactivated. Following reactivation, the virus can infect peripheral sensory nerves and stimulate peripheral pain receptors. This pain usually subsides spontaneously but in some patients may persist for an extended time.

Unfortunately there is no definitive treatment for the permanent relief of post herpetic neuralgia. Post herpetic neuralgia is a form of deafferentation pain which involves both the central and peripheral nervous systems.<sup>2</sup> Intravenous lidocaine, oral anticonvulsants, and tricyclic antidepressants have been reported to be effective in the management of post herpetic neuralgia.<sup>3</sup> Intravenous lidocaine, a cell membrane stabilizer, can provide rapid pain relief of post herpetic neuralgic pain.<sup>3</sup> Tricyclic antidepressants can decrease burning pain associated with post herpetic neuralgia while anticonvulsants can attenuate the sharp shooting pain.<sup>4</sup> Peripheral nerve blocks can provide either temporary or long-term pain relief by decreasing afferent sensory input to the dorsal

horn of the spinal cord.<sup>5</sup> Intercostal nerve blocks done with a needle and syringe are, however, not without potential side effects. A pneumothorax, intercostal nerve trauma, or a toxic plasma local anesthetic level can occur following nerve block with a needle and syringe.<sup>6</sup> We chose to use the needleless inoculating device because it has been shown not to cause a pneumothorax, pleural trauma, or cause damage to intercostal nerves when used for acute postoperative pain management in post thoracotomy or post cardiac surgery patients.<sup>7</sup> In the case presented we used one ml of local anesthetic for each intercostal nerve blocked. This is considerably less than that recommended for the needle and syringe technique.<sup>8</sup> This observation is consistent with other investigators who reported that the volume of local anesthetic is significantly less when peripheral nerves are blocked with the jet injector as opposed to the needle and syringe method.<sup>8,9</sup> In addition, jet inoculation of a liquid has been shown to produce less subcutaneous tissue damage than the needle and syringe technique.<sup>10</sup> Furthermore, blood vessels have been reported to be resistant to penetration from the liquid injectate emitted from the jet injector nozzle.<sup>11</sup> The jet injector is a rapid and relatively painless method for delivery of a liquid solution.<sup>9</sup>

It is impossible for one to determine if the treatment regime described provided relief of the pain from the post herpetic neuralgia or if spontaneous resolution of the pain occurred during treatment. However, our goal was to provide maximum analgesia in the safest manner possible considering the patient's overall medical condition until the painful entity ran its course. The patient that we presented related to us that she was pleased to discover that she did not have to suffer the psychological trauma of needle injection during her treatment.

This case report demonstrated the efficacy of the jet injector for peripheral nerve block in a patient with post herpetic neuralgia. The jet injector is under investigation for local anesthetic delivery to other peripheral nerves including myofascial areas. Not only is the device easy to use, it requires minimal training and involves no risk of needle puncture to the physician performing neural blockade of peripheral nerves.

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# Stand Up Comedy and the Practice of Medicine

Harold Bays, MD, FACP

## Diagnosis/Treatment

**A**fter being repeatedly savaged by ruthless heckling, I dropped the passive, avant-garde comedy material. Instead, I elected to assume a more finger-poppin', New York-attitude, confrontational style. Armed with the confidence of several successful performances, I entered into hostile comedy environments with confidence.

On a cold February evening, shortly after Operation Desert Storm, I attacked the comedy stage with material on the ironies of war in America. I addressed the silliness of the contrived television quotes during the Iraq invasion ("Well Jim, we are in downtown Baghdad covering the war — live! As you can see, the sky is lit up like a fireworks display — live! In fact, my right foot appears to have just been hit by a Toe Missile — live! This is a night like my podiatrist will never forget.")

However, a large number of the audience were members of a World War II airborne division. As I ranted and raved, I became aware that my new-found style elicited not laughter, but fear in these older veterans. To them, I was little less like Jay Leno and Jerry Seinfeld, and a little more like Abbie Hoffman and Jerry Rubin.

I frightened these people. I realize now that I was blinded by the spotlight. If I had evaluated the whole audience, perhaps I would have been less aggressive in my approach.

**After** being repeatedly grilled by attending physicians, fellows, and

senior residents, I elected to assume a more academic style. Armed with the confidence of successful deflections of practical, patient care questions concerning the incidence of babesiosis in Uganda, and the bedside determination of insulin's molecular structure, I entered the second year as an Internal Medicine resident with confidence.

On a cold February day, I met MK who was a 24-year-old woman who I inherited in internal medicine clinic. She had several recent ER visits for frantic complaints of palpitations and shortness of breath. With the helpful guidance of the academic attending physician, I obtained a 24-hour cardiac monitor (episodic sinus tachycardia), that prompted a 24-hour urine for metanephrines and catecholamines and thyroid blood tests (normal values), that prompted an echocardiogram ("questionable mass in the atrium"), that prompted a magnetic resonance imaging study of the heart (no diagnosis), that prompted cardiac catheterization, that demonstrated a normal heart in this 24-year-old woman.

Within a short period after the cardiac catheterization, I saw MK's brother as a patient. His medical history included a scar of the left periorbital region due to a rat-bite wound as a child, and a severed right arm related to a bus ride, a concrete tunnel, and an open window. He also had complaints of palpitations and shortness of breath diagnosed as an anxiety disorder that was well-controlled with benzodiazepines. I

suddenly felt a little less like Sir William Osler and little more like Sir I dont Hava clue.

Ms MK suffered from panic attacks. I realize now that I was blinded by the technology. If I had evaluated the whole patient, perhaps I would have been less aggressive in my approach.

## The Art of the Craft: Medical Procedures, Magic, Guitars, and Juggling

**Pure** stand up comedy is an art form. But many stand-up comics choose comedy as their vocation, not to advance the art of comedy. Despite the cry for "clean" comedy by club owners and patrons, comics soon learn that offensive language and risque material is rarely criticized as long as the comic elicits an audience response. It would be useful if all comedy clubs would inform audiences of potentially offensive comics prior to a performance.

Some comics are mostly magicians, jugglers, musicians, and/or "prop acts." Although most use these talents to enhance their comedy, some of these comics forgo comedy and perform primarily as entertainers. Audiences and club owners are often more impressed with and will pay more for the comic who can entertain than for the pure stand up comic.

**Pure** bedside diagnosis and treatment is an art form. But many physicians choose the practice of medicine as their vocation, not to advance the art of medicine. Despite the cry for cost



## Stand Up Comedy

containment by academic centers, doctors in training soon learn that ordering excessive laboratory is rarely criticized in the academic setting. When presenting the patient who presents with fever, cough, and infiltrate on chest X-ray, it is not unusual for residents to be hounded as to how they leaped to the diagnosis of "pneumonia" without the confirmatory Technetium Gerbil Scan recently described in the *Annals of Obscure and Billable Technology*. It would be useful if all medical journal articles on "How 'Real World' Physicians Should Improve Their Medical Cost Effectiveness" were accompanied by a rating as to how the author's academic center compared to the "real world" in cost effectiveness.

Some physicians' practices consist mostly of procedures. Although most physicians utilize these technical skills to enhance patient care, some forgo cognitive effort and function primarily as technicians. Patients and insurance companies are often more impressed with and reimburse more for the doctor trained in a procedural skill than for the pure diagnostician.

### Racism

TS is an innovative, introspective, and very talented African-American comic. On the last show Saturday, another African-American comic (who frequently appeared on a popular African-American stand up comedy cable program) requested to perform a "guest spot." The club agreed and TS wisely chose to go on *before* this "guest" comic. The show was extensively advertised by black radio stations. With the exception of a Caucasian couple in the front row (ie a very surprised and confused Caucasian couple), I was the only white person in the club. I had not experienced such a minority feeling since my medical training at the old

General Hospital. Nevertheless, the audience was gracious and I experienced one of the more enjoyable performances of my comedy career. It has been my observation that African-Americans are especially attuned to political issues.

TS, adorned in an impeccably tailored suit, then followed with 40 minutes of brilliant comedy. He illuminated America's social landscape — not as a member of the black race, but as a member of the human race. The chic audience applauded with their approval. It was glorious.

The "guest" comic then followed. I knew what to expect. His material would consist of excessive use of obscene language, graphic description of sexual acts, unmerciful belittling of whites, and would generally help to promote unfavorable misconceptions of African-American culture. ("It's great to see y'all here tonight. I guess yo' is glad to see me here too. 'Cause if'n I'm here, that means I ain't out in the parkin' lot stealin' yo' car.")

After witnessing to the intelligent comedy of TS, I was convinced that this educated and uptown crowd was going to reject "street comedy" as demeaning, discriminatory, prejudice, and not in the best interest of furthering the advancement of this proud people. It was clear to me the "guest comic" would die a most painful comedy death. But rather than die as I expected, he killed. The audience roared with appreciation.

Blacks and whites are not equal with respect to discrimination. Is my attitude racist, naive, or just snobbish? If I object to white comics whose comedy material heavily relies on foul language, sex, and body excrement, is it racist to be critical of blacks who do the same? After all, not having been a member of an African-

American family, I may not fully appreciate the culture.

It has been suggested that much of the increased health risk of African-Americans, such as high blood pressure, may be due to suppressed anger and anxiety from repetitive encounters with racism. Initially, I found this a medical stretch at best. Because it is the 1990s, surely racism is no longer a major factor for most blacks. Clearly, it seemed, the increased risk of such problems as high blood pressure, heart disease, and stroke is simply that too many African-American foods (and therefore too many African-American persons) contain too much fat and salt.

Shortly afterward, a friend from a progressive city in the Midwest told me of how she and her coworkers were recently invited by one of her colleagues to go out to lunch. She was astounded to discover that the leader of the group had first called the "club" to ask permission to bring SQ, who was an African-American woman professional. During our conversation, my friend and I both wondered if SQ knew that she was the only black person in the club, except for the servers and cleaning staff. We both wondered if SQ knew that the club had to give "permission" in order for her to join her friends for lunch. We both wondered if SQ knew her blood pressure.

Blacks and whites are not equal with respect to the risks of many medical conditions such as diabetes, hypertension, kidney and heart disease. But how much of attributable risk is due to genetic predisposition, how much is due to social issues, and how much is due to the high intake of fat and salt of many African-Americans? If I object to obese white patients with high cholesterol blood levels who eat cow brains (that are

very high in cholesterol), is it racist to be critical of obese, adult onset diabetic, hypertensive black patients who eat cow feet, salt pork, and fatback? After all, not having been a member of an African-American family, I may not fully appreciate the culture. After all, not having been a member of a cow brain-consuming white family, I may not fully appreciate my own culture.

### **Road Comedy, Research and Family**

**"Road comics"** travel from town to town, spending days in hotel rooms or comedy housing provided by the comedy club. The typical features of "road comedy" housing include mismatched furniture and dishes, worn-through carpet, and numerous crusted, once opened mustard and mayonnaise jars in the refrigerator. And there is the "information wall." This is the area above the phone with handwritten comments of previous comics, as well as vital phone numbers of the comedy club, calling card operators, and various pizza delivery services.

Early in their careers, the success of road comics is highlighted by noting the success of other comics he/she has worked with in the past. Progressively, the success of road comics becomes more dependent on the status of the clubs they have worked, the articles they have had written about them, and the number of TV performances they have made.

In addition to monetary and professional success, many road comics find a major appeal of stand up comedy is the concept of family.

Because so many road comics work so many clubs with so many other comics, a comedy "family" is created. Comics can spend a large part of their day in the condo critiquing the accomplishments and comedy bits of their colleagues, as well as espousing their esoteric theories of comedy and the comedy industry. And if a road comic does happen to obtain success through a TV spot, their colleagues soon assimilate this information into their comedy collective and the event becomes a benchmark for future discussions. Every success and failure of a stand up comic enhances and solidifies the comedy family.

### **Medical "bench" researchers**

often train and work from one academic center to another, spending days in the lab provided by the academic institution. The typical features of a research laboratory include mismatched beakers and test-tubes, worn-through tile over concrete floors, culture plates and blood samples of unclear origin and purpose, and numerous crusted, once opened mustard and mayonnaise jars in the refrigerator. And there is the "information wall." This is the area above the phone with handwritten comments of previous researchers, clinical coordinators, and lab techs, as well as the vital phone numbers of the reference laboratories, study monitors, and various pizza delivery services.

Early in their careers, the success of the researcher is highlighted by noting the success of other researchers he/she has worked with in

the past. Progressively, the success of researchers becomes more dependent on the status of the academic institution they have worked, the articles they have published, and the number of grants obtained or the number of drug trials they have performed.

In addition to monetary and professional success, many researchers find a major appeal of research is the concept of family. Because so many researchers go to so many meetings attended by so many other researchers, a research "family" is created. Research investigators can spend a large part of their evenings at meetings critiquing the accomplishments and research of their colleagues and espousing their esoteric theories of medical pathophysiology and the medical research industry. And if a researcher does happen to become published in a major journal, the other researchers will soon assimilate this information into their academic collective, and the publication becomes a benchmark for future discussions. Every success and failure of a medical researcher enhances and solidifies the research family.

### **Conclusion**

Comedy can sometimes be medicine; medicine can sometimes be comical. Although we may fancy our experiences as unique, we all follow the same path, but in different forests. Sometimes it's just hard to see above the trees.

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*Dr Bays is a practicing endocrinologist. He performs comedy as a hobby.*





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# Beepers Are Our Friends

**F**rom beep to beep my automatic reaction to the little Motorola radio which follows me more faithfully than a loyal old dog is one of horror at the brazen intrusion into my content privacy. I've been unable to purge this emotional reaction despite my serious rationalizations that this is the easy, cost effective, efficient means of prompt communication that my professional activity requires.

Such prejudice as I may have had against the radio page has been entirely overcome by the advent of the cellular telephone.

Professional telephone communication is a serious affair. It requires full attention to what one hears and what one says. In my instance, it requires notes: those to be read and incorporated into what I say and those to be made and be used both now and in the future from what I hear.

Driving a car is a serious affair. It's a fascinating and challenging game. It's a recreational release, absorbing fun, a sensual pleasure and a timely respite between professional communications. It is dangerous, treacherous and should be accorded full attention, much like professional telephone communication. Since I am too apprehensive to do both together, the Motorola reminds me every two minutes to make a telephone call.

**A. Evan Overstreet, MD**  
Editor

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*“Such prejudice as I may have had against the radio page has been entirely overcome by the advent of the cellular telephone.”*

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## 1995

## FEBRUARY

19-24 — 26th Annual Family Medicine & Primary Care Review — Session I (3 identical sessions), Hyatt Regency Hotel, Lexington, KY. Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

## MARCH

8-10 — Nuclear Oncology, sponsored by Johns Hopkins Medical Institutions, Baltimore, MD. Contact: Jeanne Ryan, Program Coordinator, Johns Hopkins Medical Institutions, Office of Continuing Education, Turner Building, 720 Rutland Ave, Baltimore, MD 21205; 410/955-2959; or Julia W. Buchanan, Course Co-director, 410/955-8582.

17-18 — 23rd C. Dwight Townes Memorial Seminar, University of Louisville, Dept of Ophthalmology. Contact: Nancy Rodman, 502/852-5466.

## APRIL

7-8 — Office Endocrinology, Radisson Plaza Hotel, Lexington, KY. Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204/6333; FAX 606/323-2008.

22-23 — Topics in Geriatrics, Radisson Plaza Hotel, Lexington, KY. Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204/6333; FAX 606/323-2008.

28-May 5 — 54th Annual American Occupational Health Conference, Sands Expo and Convention Center, Las Vegas, NV. Contact: ACOEM, 55 W Seegers Rd, Arlington Heights, IL 60005; 708/228-6850; FAX 708/228-1856.

## MAY

12-13 — Contemporary Pediatrics for the Primary Care Physician, Hyatt Regency Hotel, Lexington, KY. Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

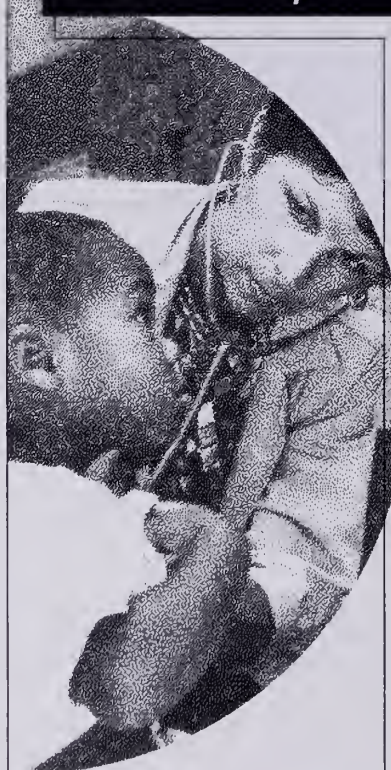
21-26 — 26th Annual Family Medicine & Primary Care Review — Session II, Hyatt Regency Hotel, Lexington, KY. Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

## JUNE

8-10 — Advanced Life Support in Obstetrics, Holiday Inn North, Lexington, KY. Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

## CALL TODAY

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Family Medicine Review	\$525
	42 credit hours
ACLS and Review	\$725
	56 credit hours

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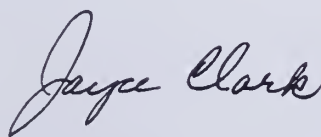
# We're Involved

Physicians and their spouses donate many hours each week in volunteer service to their communities. Have you, as a physician or physician's spouse ever thought about the time spent on community involvement? This involvement takes place in many areas and in many ways. Some spend their hours working with the schools and their projects; some as a scout leader or helper, as a Sunday school teacher, or work with Hospice; some serving on the fine arts boards, or chairing the United Way. Each time one of us spends time in some way promoting, serving, or leading an organization in our communities, this is volunteer community service.

This year the American Medical Association Alliance will be recognizing volunteers of the Alliance for the month of March. This is also the month when we celebrate Doctors' Day. In our state we will be combining the efforts of physicians and their spouses when we celebrate Alliance Month and Doctors' Day. Our county alliances will be saluting volunteerism with special publications in the various state newspapers. Many people do not realize what physicians and their spouses give to their local communities in service and dedication. It is time that we "toot our own horn" and let the public see us

for what we are and what we do — not where we live, or what kind of car we drive.

It is true that physicians, because of their ability to generate income, usually live in the better neighborhoods and have many luxuries. These come with a price and they come because physicians are willing to work long hours and accept great responsibility. Many hours are spent by physicians and their spouses working in community related projects. We need to salute ourselves and our many accomplishments. Join with us in celebrating "Alliance Month" and "Doctors' Day" during the month of March.



**KMA Alliance President**

If your spouse is a member of the AMA Alliance and has not been receiving its publication, *FACETS*, please contact the KMA office, 301 N Hurstbourne Pkwy, Suite 200, Louisville, KY 40222, Attn: Jean Wayne; phone 502/426-6200.




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*"Many hours are spent by physicians and their spouses working in community related projects. We need to salute ourselves and our many accomplishments."*

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# ***SPECIAL ANNOUNCEMENT***

## **Meeting the Changing Needs of Doctors and the Healthcare Community THE MEDICAL PROTECTIVE COMPANY**

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In response to these changes, The Medical Protective Company is pleased to clarify our policy provisions regarding hold harmless agreements... **Effective immediately, The Medical Protective Company will defend and indemnify any third party with whom you have signed an indemnification agreement in any suit brought against that third party based solely on your professional services.** This clarification applies to all policies in force, including any occurrence policies from prior years.

While we can interpret our contract, state law does not allow us to interpret the contract(s) of others. Please seek the advice of your personal attorney as the best source for review of third party contracts. We hope this clarification of our policy will help you in managing your practice. Please feel free to contact your General Agent at (800) 344-1899.

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# KMA Board of Trustees — December Meeting

The KMA Board of Trustees held its 1994 winter meeting at the Oxmoor Country Club on December 14 and 15. The Board members heard routine reports of the President; Secretary-Treasurer; Senior Delegate to AMA; Alliance President; Dean, University of Kentucky Medical Center; Chair, KEMPAC Board of Directors; Chairman, KMIC Board of Directors; Commissioner for Health Services; and Board of Medical Licensure. In addition, special presentations were given by James B. Holloway, Jr, MD, Medical Director of the Medicare Part B Program in Kentucky; and by Beverly M. Gaines, MD, the physician member of Kentucky's newly created Health Policy Board.

Committee Chairs gave extensive reports, and highlights include:

**Membership Committee** — A steady increase in membership was reported with 1994 year-end total of 6,151, and 4,194 Active Members.

**Committee on State Legislative Activities** — Plans are underway to introduce an amendment to Section 54 of the Kentucky Constitution that would permit the General Assembly to limit the amount recoverable for noneconomic loss, punitive damages, and all other nonpecuniary damages arising from injuries resulting in death, or injuries to person or property.

The Committee was also authorized by the Board to look at onerous portions of HB 250, with the idea of introducing legislation to overturn such sections, with the Executive Committee to act as monitor.

**Committee on National Legislative Activities** — National health care reform efforts have been redirected to small-scale, incremental changes.

**Committee on Medical Insurance and Prepayment Plans** — The KMA Insurance Agency will continue to work with Blue Cross and Blue Shield to devise an enhanced group health care package for the membership, with renewal of the current contract extended until June 1, 1995.

In response to Resolution K (1993),

the Committee will continue to develop a closer liaison with major insurance carriers; in response to Resolution J (1993), the Committee recommended as KMA policy, and the Board concurred, that an attending surgeon is the individual best qualified to determine whether or not an assistant surgeon is needed, and if so, the assisting physician should be compensated fairly. In implementing Resolution A (1994), the Board accepted the Committee's recommendation that KMA identify those insurance companies that would allow a "passthrough" of the tax imposed on physician gross revenues by 1994 House Bill 250.

**Committee on Public Education** — In reference to HB 250, the Committee authorized the printing of bumper stickers stating "Repeal the Tax," as well as sample letters members and their patients can send to legislators regarding the tax.

In other committee activity, the Board Chair appointed the KMIC Board Election Nominating Committee, and a new Chair of the Committee on Continuing Medical Education.

Legal Counsel brought the Board members up to date on several legal matters in which KMA was involved. It was reported that the US Supreme Court

had denied KMA's Petition for a Writ of Certiorari on HB 1, a previous provider tax bill, which let stand a Kentucky Supreme Court ruling that the tax was not unconstitutional.

A lengthy report was also given on KMA's lawsuit challenging the proposed decrease in Medicaid reimbursement, and the Board authorized funds from the Legal Trust Fund to continue the litigation. The Board also agreed that it was premature to legally challenge the Discount Option Program, but that a lawsuit could be considered at an appropriate time. It was noted that monies in KMA's Legal Trust Fund are being rapidly depleted, and options for funding will be considered before the next Board meeting.

In other action, the Board members appointed Jaroslav P. Stulc, MD, Madisonville, to the editorial Board of the *Journal of the Kentucky Medical Association*; submitted the name of James R. Smith, MD, Shelbyville, to the Board of Medical Licensure for appointment to its Physician Assistant Advisory Committee; and selected several physicians for service on a BCBS Workers' Compensation Advisory Committee.

The next meeting of the KMA Board of Trustees was scheduled for April 12-13, 1995, in Louisville. *KMA*



L to R, Board Chair Donald R. Stephens, MD, President Robert R. Goodin, MD, and President-Elect Danny M. Clark, MD.



## The "Mother of Rowan County" Named Country Doctor of the Year



**E**ighty-two-year-old Claire Louise Caudill, MD — the "mother of Rowan County, Kentucky" — has been named 1994/95 Country Doctor of the Year.

The national award is conferred annually by the Country Doctor Museum in Bailey, NC, and by Staff Care, Inc, an interim physician staffing firm in Irving, TX, to honor the spirit, skill and dedication of America's rural physicians.

"Dr Louise," as she is known throughout northeastern Kentucky, has been an active member of KMA for 46 years. She has a remarkable personal history and record of service that includes:

- Forty-six years of continual practice in Morehead, Kentucky.
- Delivery of approximately 8,000 babies, 2,000 of them home deliveries.
- Establishment of a hospital in Morehead.
- Depiction as a central character in *Rowan's Progress* a book by noted Cornell University professor and frequent New Yorker contributor James McConkey.
- Establishment of a largely Medicare/Medicaid practice in one of the poorest areas of the country. Dr Caudill's patients pay if they can and bills are sent only twice a year.

A native of Morehead, Claire Louise Caudill is a member of a distin-

guished northeastern Kentucky family. Her father, Daniel Boone Caudill, claimed descent from the great woodsman, and Dr Caudill is related to the infamous Craig Tolliver, one of the most blood-stained participants in the legendary Martin-Tolliver feud. Indeed, as a girl, Dr Caudill witnessed the last shooting that took place in what is known as the "Rowan County War."

Dr Caudill attended Ohio State University, and for 7 years taught physical education at Morehead State University in Morehead. Unsatisfied, she decided to pursue her dream of becoming a doctor and was one of only two women out of 100 students in 1946 to graduate from the University of Louisville Medical School.

Dr Caudill returned home to set up as a family practitioner. With her was Susie Halblieb, a nurse she had met while doing her internship. Halblieb agreed to help Dr Caudill in her new practice for 1 year. Instead, she stayed in Morehead for 46 years as Dr Caudill's nurse, a position she still holds.

"Dr Louise and Susie" became familiar figures, trudging through streams and up dirt roads to bring care to people in the surrounding mountains. Their mode of operation is best described by McConkey in *Rowan's Progress*.

"Often Louise and Susie would meet the husband of a woman in labor at a predetermined point, the point beyond which no car could safely go. The man would have a horse or a mule, sometimes attached to a wagon, but more frequently to a flat-bottomed sled, for such sleds could traverse mud as well as snow far better than a wheeled vehicle."

The doctor and nurse team would wait with the expectant mother, sometimes for days in cabins without heat or running water, until the baby was born.

In 1957, Dr Caudill and nurse Halblieb opened their own maternity clinic in Morehead, complete with a delivery room, two labor rooms, and an X-ray room — amenities that were hitherto unknown in the area. The clinic included a small apartment in the back,

where Dr Caudill and Susie lived so that they could deliver care around the clock. Dr Caudill estimates that she and Susie delivered about 600 babies a year during this period, or roughly as many as the entire obstetrics department at the 159-bed hospital she founded now delivers annually.

It was a pace that even the indefatigable duo could not keep up. Dr Caudill knew that a hospital was essential for the area, as the closest facility was 70 miles away over narrow roads, and patients were dying before they could obtain treatment. She personally led the effort to make the dream of a hospital a reality.

"We had kids going door-to-door and having backyard circuses to come up with donations of \$57.26 and such," Dr Caudill relates.

Eventually, Dr Caudill spearheaded an effort that raised \$294,000, a major sum for a poor mountain community in 1960. Dr Caudill next made an impassioned plea to the Sisters of Notre Dame to fund the rest of the project and to help staff and manage the hospital. When an official from the Catholic Church made a surprise visit to Morehead and saw the six babies Dr Caudill had just delivered in the clinic — several of them lying on the couch because all the bassinets were full — the deal was clinched.

The hospital was completed just 3 years later and was named "St. Claire Medical Center" in honor of Claire Louise Caudill. It has since grown into a highly respected facility, with its own cancer treatment center, numerous specialists, a maternity center, a thriving home health care department, and a hospice.

Dr Caudill has kept up her practice, her involvement in community affairs, and her countless friendships with people whom she delivered, their children and their children's children. Though she no longer delivers babies, she still sees about 20 patients a day, four days a week.

"There are times when I'd like to prop up my feet," she confesses, "but I really wouldn't have it any other way."

## PEOPLE



Judy Linger, MD

**Judy Linger, MD**, UK psychiatry resident, was elected Chair-Elect of the Governing Council of the American Medical Association Resident Physicians Section. The election took place at the AMA-RPS Interim Meeting held December 1-3 in Honolulu. Dr Linger is currently President of the KMA-RPS and has been active at the national level both as a medical student and resident. She is a past Chair of the AMA-MSS and has most recently served as Alternate Delegate to the AMA from the AMA-RPS.

**Jannice O. Aaron, MD**, has been named a member of the Kentucky Spinal Cord and Head Injury Research Board. The appointment was made by Governor Brereton Jones. Dr Aaron is acting chair of the U of L Department of Diagnostic Radiology.

**Patricia Wheeler, MD**, received a 1994 Mead Johnson Award for Graduate Education for Family Medicine. She was honored at an assembly of the American Academy of Family Physicians as one of the most outstanding family practice residents in the country. She was

chosen for achievements and outstanding commitment to family medicine ideals.

**John S. Spratt, MD**, was voted president-elect of the Kentucky Division of the American Cancer Society at their 1994 annual meeting.

**Gloria J. Griffin**, immediate past president of the KMAA is currently serving on the American Medical Association Alliance Membership Development Committee.

## UPDATES

## Prescription Requirements

The Kentucky Pharmacists Association is seeking support in ensuring that physicians abide by the requirements of KRS 217.216 which states:

*"Every prescription order written by a practitioner authorized by statute to prescribe under this chapter and KRS Chapter 18A shall bear upon the prescription blank the name, telephone number, and business address of the prescribing practitioner."*

Several complaints have been received from pharmacists who have been presented prescriptions which do not contain the required information. In most cases, according to the KPhA, it appears prescriptions were written on blanks provided by a medical center, clinic, or hospital emergency room.

Dispensing a prescription absent the statutorily required information places the pharmacist in jeopardy for providing medications based upon an "illegal" order. The net effect of prescribers' failure to provide the required name, telephone number, and business address is that some patients may be denied access to needed medications.

## Are You Still Paying For Your Medical Education?

Let the Establish Practice Grant Program (EPGP), through the Rural Kentucky Medical Scholarship Fund, Inc (RKMSF) and the KMA, help you ease your burden.

If you are a licensed physician who has completed an LCME approved primary care residency and are practicing primary care medicine you may be eligible.

The purpose of the EPGP is to help defray educational debt of participants. This grant offers \$10,000 per annum for a maximum of 4 years, or \$40,000. In return, the participant must practice Primary Care medicine full time in an approved *critical* county of Kentucky. For each year practiced in a critical county, the participant will receive a grant for \$10,000 payable to himself and a lending institution(s).

There are currently *four* vacancies for the EPGP. If you are interested, please contact the RKMSF office at 301 N Hurstbourne Parkway, Suite 200, Louisville, KY 40222, or call 502/426-6200 for more information or an application.

## Do You Know Someone Entering Medical School in Kentucky?

The Rural Kentucky Medical Scholarship Fund, Inc is accepting applications from residents of Kentucky, who have been accepted at the University of Louisville Medical School. The Fund offers a \$10,000 loan for each year of medical school to a qualified recipient who is willing to practice and reside in a rural county in Kentucky for 1 year for each loan received. The low interest rate is determined on May 1. Repayment options include low interest rates for recipients practicing in rural areas and loan forgiveness for those practicing in areas of the state with critical needs.



The Fund is the oldest and most successful of its kind in the nation. The Rural Kentucky Medical Scholarship Fund has made loans to over 560 recipients since 1946. The deadline for filing an application is April 1, 1995. Those interested in applying should contact the RKMSF Office at the Kentucky Medical Association Headquarters, 301 N Hurstbourne Parkway, Suite 200, Louisville, KY 40222, or call 502/426-6200.

### U of L Doctors Perform Operation Allowing Greater Freedom for Cancer Patients

The University of Louisville reports that a team of their doctors have performed the first Kentucky operation to place a flexible metal stent in a patient with advanced esophageal cancer. The stent compresses the patient's tumors, clearing throat blockages so he can eat and drink normally. The patient received the stent in an outpatient procedure at University of Louisville Hospital.

**Whitney F. Jones, MD**, director of therapeutic endoscopy/endoscopic oncology at the School of Medicine, performed the procedure.

The expandable wire mesh stent used in the procedure is compressed in a narrow catheter and placed in the esophagus through an endoscope. As the catheter is gently withdrawn, the stent expands until it lodges against the esophageal wall, compressing tumors that have narrowed the passageway.

Without treatment, most patients with advanced esophageal cancer can't swallow anything — sometimes not even their own saliva, Dr Jones explained. The rigid plastic stents that were the predecessors of this newer procedure allow for fluid consumption but can't accommodate solid food. "With the wire mesh stent, patients can eat pretty much a

standard diet," Dr Jones said.

The particular model used in this procedure has the added benefit of an inner coating that discourages new tumor growth inside the wire mesh, thus keeping the passageway clear. "We were looking at how patients could spend the least amount of time in the hospital and experience the least discomfort," said Dr Jones.

The stents are one of many options now available to patients with nonoperable esophageal cancer, explained Dr Jones. "It won't add years to the life of these cancer patients, but it will add life to the years or months remaining."

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### NEW MEMBERS

*Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.*

#### Boyle

**Brian E. Ellis, MD** — FP  
109 Daniel Dr, Danville 40422  
1990, Medical Col of Georgia

#### Carroll

**Robert D. Harris, MD** — S  
203 Marwill Dr, Carrollton 41008  
1965, Wayne State

#### Clay

**Susan A. Adeife-Adeyinka, MD** — PD  
PO Box 1356, London 40743  
1986, U of Lagos

#### Daviess

**Gerald N. Sims, Jr, MD** — RHU  
4 Hilltop Dr, Owensboro 42303  
1985, LSU

#### Floyd

**Mark P. Caruso, MD** — IM  
PO Box 29, Prestonsburg 41653  
1979, Hahnemann Med Col

#### Franklin

**William T. Timmons, MD** — OBG  
7 Physicians Park, Frankfort 40601  
1975, Baylor

#### Jefferson

**Brad Angle, MD** — PD  
6116 Deep Creek Dr, Prospect 40059  
1983, U of Chicago

**Mary M. Bryant, MD** — IM  
4003 Kresge Way #335, Louisville 40207

1991, U Texas, Houston  
**Perry B. Cassady, MD** — OBG  
608 Medical Towers N, Louisville 40202

1990, Indiana U  
**Jane E. Brooks Cornett, MD** — IM  
1169 Eastern Pky #2358, Louisville 40217

1987, U of Louisville  
**Dana J. Distler, MD** — PD  
1004 Golden Maple Cove, Louisville 40223

1991, U of Kentucky  
**Jorge E. Isaza-Rojas, MD** — ORS  
210 E Gray St #601, Louisville 40202

1981, U of DelValle  
**Whitney F. Jones, MD** — GE  
967 Greenridge, Louisville 40206

1987, U of Louisville  
**Raul Madrid-Linares, MD** — AN  
9115 Leesgate Rd #C, Louisville 40222

1987, U of Javeriana  
**Bryan D. Murphy, MD** — OTO  
4003 Kresge Way #227, Louisville 40207

1989, U of Louisville  
**Julene B. Samuels, MD** — PS  
225 Abraham Flexner #403, Louisville 40202

1987, U of Kentucky  
**Marion Sovic, MD** — AN  
9115 Leesgate Rd, Louisville 40222

1987, Texas Tech  
**Robert C. Stewart, MD** — S  
250 E. Liberty #500, Louisville 40202

1988, U of Louisville  
**Charles D. Webb, MD** — HEM  
3301 Springstead Cir, Louisville 40241

1987, U of Louisville  
**Patricia W. Wheeler, MD** — FP

417 Iola Rd, Louisville 40207  
1991, U of Louisville

#### Laurel

**Helmut J. Jungschaffer, MD** — PD  
1406 W 5th St, London 40741  
1987, Albert Ludwig U

#### Lawrence

**Marc A. Workman, MD** — FP  
412 N Locke, Louisa 41230  
1986, Marshall U

#### Northern Kentucky

**Wesley Braden, III, MD** — R  
170 Barnwood Dr, Edgewood 41017  
1987, U of Kentucky

**Attef A. Mikhail, MD** — R  
1004 Park Dr, Park Hills 41011  
1986, U of Cincinnati

**Gary M. Schmitt, MD** — R  
170 Barnwood Dr, Edgewood 41017  
1988, Northeastern Ohio U

**Jeffrey L. Schmitter, MD** — R  
170 Barnwood Dr, Edgewood 41017  
1981, Northeastern Ohio U

**Jackie S. Sweeney, MD** — R  
112 W Orchard Rd, Covington 41011  
1985, U of Kentucky

**Manuel S. Villareal, MD** — A  
333 Madison, Covington 41011  
1984, Emilio Aganaldo Col

**Scott W. Spann, MD** — ORS  
12115 Sheraton Ln, Cincinnati 45246  
1986, U of South Carolina

#### Warren

**Alan M. Taylor, II, MD** — C  
5528 Three Springs Rd, Bowling Green  
42104  
1986, Loyola

#### In-Training

#### Fayette

**Ralph A. Alvarado, MD** — IM

#### Jefferson

**Joseph S. Bird, Jr., MD** — REN  
**Herbert H. Boyd, MD** — OBG  
**A. Frances Brennan, MD** — IM  
**Pamela M. Hill, MD** — OBG  
**Samer H. Hussein, MD** — IM

**Goetz H. Kloecker, MD** — IM  
**James R. Martin, MD** — IM  
**Mary Margaret Miller, MD** — FP  
**Robin B. Oukrop, MD** — IM  
**Lawrence R. Rouben, MD** — IM

**Lawrence T. Minish, MD**  
**Louisville**  
**1912-1994**

Lawrence T. Minish, MD, an internist, died December 28, 1994. Dr Minish was a 1936 graduate of the University of Louisville School of Medicine and a life member of KMA.

#### DEATHS

**Raymond E. Jones, MD**  
**Venice, FL**  
**1918-1994**

Raymond E. Jones, MD, a retired otolaryngologist, died October 25, 1994. Dr Jones was a 1945 graduate of the University of Louisville School of Medicine and was a life member of KMA.

**Carl B. Nagel, MD**  
**Monticello**  
**1932-1994**

Carl B. Nagel, MD, a surgeon, died November 7, 1994. A 1956 graduate of Stanford University School of Medicine, Dr Nagel was an active member of KMA until 1993.

**John Watts, MD**  
**Pewee Valley**  
**1920-1994**

John Watts, MD, a retired radiologist, died November 9, 1994. Dr Watts graduated from the University of Louisville School of Medicine in 1951 and was a life member of KMA.

**Clifford V. Jennings, MD**  
**Louisville**  
**1944-1994**

Clifford V. Jennings, MD, an oncologist, died December 4, 1994. A 1970 graduate of the University of Louisville School of Medicine, Dr Jennings was an active member of KMA.

### KMA Practice Management Workshops

#### March

**Better Collections,  
Billing and Insurance  
Methods**  
(half-day)

**Reception/Patient  
Flow Techniques**  
(half-day)

**March 15 - Louisville**

Attend one or both  
workshops to improve  
important office skills.

**How to Get Started in  
Medical Practice**  
**March 16-17**  
**Louisville**

A 1-1/2 day workshop for  
new physicians or those  
changing practice

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for further information.



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Antiminth® (Pyrantel pamoate) OTC  
Caritril® Topical Ointment 1% (Hydracartisane) Rx  
Diabinese® Tablets (Chlorpropamide) Rx  
Diabinese® Tablets Unit-Dose Pak (Chlorpropamide) Rx  
Feldene® Capsules (Piraxicam) Rx  
Feldene® Capsules Unit-Dose Pak (Piraxicam) Rx  
Minipress® Capsules (Prazasin HCl) Rx  
Minipress® Capsules Unit-Dose Pak (Prazasin) Rx  
Minizide® 1 Capsules (1 mg. Prazasin and 0.5 mg. Palythiazide) Rx  
Minizide® 2 Capsules (2 mg. Prazasin and 0.5 mg. Palythiazide) Rx  
Minizide® 5 Capsules (5 mg. Prazasin and 0.5 mg. Palythiazide) Rx  
Maderil® Tablets (Rescinnamine) Rx  
Narvasc® (2.5, 5 and 10 mg.) Rx  
Renese® Tablets (Palythiazide) Rx  
Renese®-R Tablets (2 mg. Palythiazide and 0.25 mg. Reserpine) Rx  
Sustaire® (Theophylline anhydrous) Rx

Terramycin® Capsules (Oxytetracycline HCl) Rx  
Vansil® Capsules (Oxamniquine) Rx  
Vibra-Tabs® (Daxycycline hyclate) Rx  
Vibra-Tabs® Unit-Dose Pak (Daxycycline hyclate) Rx  
Vibramycin® Calcium Syrup (Daxycycline calcium oral suspension) Rx  
Vibramycin® Hyclate Capsules (Daxycycline hyclate) Rx  
Vibramycin® Hyclate Capsules Unit-Dose Pak (Daxycycline hyclate) Rx  
Vibramycin® Manahydrate for Oral Suspension (Daxycycline manahydrate) Rx  
Vistaril® Capsules (Hydroxyzine pamoate) Rx  
Vistaril® Capsules Unit-Dose Pak (Hydroxyzine pamoate) Rx  
Vistaril® Oral Suspension (Hydroxyzine pamoate) Rx  
Zithramax® Capsules (Azithromycin)

## Roerig

Antivert® (Meclizine HCl) Rx  
Antivert® Tablets Unit-Dose Pak (Meclizine HCl) Rx  
Atarax® (Hydroxyzine HCl) Rx  
Atarax® Tablets Unit-Dose Pak (Hydroxyzine HCl) Rx  
Banine® Chewable Tablets (Meclizine HCl) OTC  
Cardura® Tablets (Doxazosin Mesylate) Rx  
Cefabid® (Cefaperazone sodium) Rx  
Diflucan® (Fluconazole) Oral and Parenteral Antifungal Rx  
Diflucan® (Fluconazole) Unit-Dose Pak Oral and Parenteral Antifungal Rx  
Emete-can® IM/IV (Benzquinamide HCl) Rx  
Geacillin® (Carbenicillin indanyl sodium) equivalent to 382 mg. carbenicillin Rx  
Geopen IM/IV (Carbenicillin disodium) Rx  
Heptuna® Plus Capsules (Iron plus vitamins and minerals) Rx  
Hydracartisane Powder (Hydracartisane USP micronized) Rx  
Isaject® Permapen® (Penicillin G benzathine) Aqueous Suspension Rx  
Marax® (Hydroxyzine HCl [ATARAX®]-Theophylline-ephedrine sulfate) Rx  
Navane® Capsules (Thiathixene) Rx  
Navane® Capsules Unit-Dose Pak (Thiathixene) Rx  
Navane® Concentrate (Thiathixene HCl) Rx  
Navane® Intramuscular (Thiathixene HCl) Rx  
Pfizerpen® for Injection (Penicillin G potassium) Buffered Rx

Pfizerpen®-AS (Penicillin G procaine) Aqueous Suspension Rx  
Palmyxin B Sulfate Sterile Rx  
Sinequan® Capsules (Doxepin HCl) Rx  
Sinequan® Capsules Unit-Dose Pak (Doxepin HCl) Rx  
Sinequan® Capsules Unit of Use Pak (Doxepin HCl) Rx  
Sinequan® Oral Concentrate (Doxepin HCl) Rx  
Spectrabid® Oral Suspension (Bacampicillin HCl) Rx  
Spectrabid® Tablets (Bacampicillin HCl) Rx  
Streptomycin Sulfate Rx  
Tao® Capsules (Troleandomycin) Rx  
Terra-Caritril® Ophthalmic Suspension (Oxytetracycline HCl and hydracartisane acetate) Rx  
Terramycin® Intramuscular Solution (Oxytetracycline) Rx  
Terramycin® Ophthalmic Ointment with Palmyxin B Sulfate (Oxytetracycline HCl with palmyxin B sulfate) Rx  
Terramycin® Vaginal Tablets with Palmyxin B Sulfate (Oxytetracycline HCl with palmyxin B sulfate) Rx  
Unasyn® (Ampicillin sodium/sulbactam sodium) Rx  
Urbatic® 250 (250 mg. Oxytetracycline HCl 250 mg. sulfamethizole 50 mg. phenazopyridine HCl) Rx  
Vibramycin® Intravenous (Doxycycline hyclate for injection) Rx  
Vistaril® Intramuscular Solution (Hydroxyzine HCl) Rx  
Vistaril® Intramuscular Solution Unit-Dose Vials (Hydroxyzine HCl) Rx  
Zalaf® Tablets (Sertraline) Rx

## Pratt Division

Glucotrol® Tablets (Glipizide) Rx  
Glucotrol® Tablets Unit-Dose Pak (Glipizide) Rx  
Feldene® Capsules (Piraxicam) Rx  
Feldene® Capsules Unit-Dose Pak (Piraxicam) Rx  
Pracardia® Capsules (Nifedipine) Rx

Pracardia® Capsules Unit Dose Pak (Nifedipine) Rx  
Pracardia XL® (Nifedipine) Extended Release Tablets Rx  
Pracardia XL® (Nifedipine) Extended Release Tablets Unit-Dose Pak Rx  
Zalaf® Tablets (Sertraline) Rx

## Searle

Aldactazide® tablets (spironolactone with hydrochlorothiazide)  
Aldactone® tablets (spironolactone)  
Calan® SR caplets (verapamil HCl)  
Calan® caplets (verapamil HCl)  
Cytotec® tablets (misoprostol)

Kerlane® tablets (betaxolol HCl)  
Nitradisc® discs (nitroglycerin)  
Narpace® capsules (disopyramide phosphate)  
Narpace® CR capsules (disopyramide phosphate)

# PHARMACEUTICALS AVAILABLE TO KENTUCKY PHYSICIANS CARE

These Johnson & Johnson pharmaceuticals may be prescribed and dispensed under the program:

## Iolab Corporation

Argyrol® S.S. (mild silver protein)  
Atropisol® Ophthalmic Solution (atropine sulfate)  
Catarase® (chymotrypsin)  
Dexacidin® Ophthalmic Suspension and Ointment (dexamethasone, neomycin and polymyxin B. sulfates)  
Dexamethasone Sodium Phosphate Ophthalmic Solution 0.1%  
Dexamethasone Sodium Phosphate 4 mg/ml (for injection)  
Epinephrine  
E-PILO® Ophthalmic Solution (epinephrine bitartrate-pilocarpine HCl)  
Eserine Sulfate Sterile Ophthalmic Solution  
Fluorescein Sodium  
Fluor-Op® Ophthalmic Suspension (fluorometholone .1%)  
Funduscein® -10, -25 Injection (fluorescein sodium)  
Gentacidin® Solution and Ointment (gentamicin sulfate)  
Gentamicin 40 mg/ml, 80 mg/2 ml (for injection)  
Glucose-40 Sterile Ophthalmic Ointment  
Homatropine Hydrobromide  
Inflamase® Forte Ophthalmic Solution (prednisolone sodium phosphate)

Inflamase® Mild Ophthalmic Solution (prednisolone sodium phosphate)  
Iocare® Balanced Salt Solution  
Mioclar® Intraocular & System Pak (acetylcholine chloride)  
Neomycin, Polymyxin B sulfates, and Hydrocortisone Ophthalmic Suspension  
Neamycin, Polymyxin B sulfates, and Gramidicin Ophthalmic Solution  
Neamycin Sulfate/Dexamethasone Sodium Phosphate Ophthalmic Solution  
Phenylephrine HCl 10%/2.5%  
Pilocar® Ophthalmic Solution (pilocarpine HCl)  
Sulf-10® Ophthalmic Solution (sodium sulfacetamide)  
Tetracaine HCl  
Vasocidin® Ophthalmic Solution (sulfacetamide sodium-prednisolone sodium phosphate) & Ointment (sulfacetamide sodium-prednisolone acetate)  
Vasocon-A Ophthalmic Solution (naphazoline HCl-antazoline phosphate)  
Vasocon Regular Ophthalmic Solution (naphazoline HCl 0.1%)  
Vasosulf® Ophthalmic Solution (sulfacetamide sodium-phenylephrine HCl)

## Janssen Pharmaceutica, Inc.

\*Duragesic® Transdermal system (fentanyl)  
Ergamisol® Tablets (levamisole HCl)  
Hismanal® Tablets (astemizole)  
Imodium® Capsules (loperamide HCl)

Nizoral® Cream (ketoconazole)  
Nizoral® Shampoo (ketoconazole)  
Nizoral® Tablets (ketoconazole)  
Vermox® Tablets (mebendazole)

## McNeil Consumer Products Company

Chemet® Capsules (succimer)

Pediparfen™ Suspension (ibuprofen)

## McNeil Pharmaceutical

Floxin® Tablets (ofloxacin)  
Haldol® Tablets and Concentrate (haloperidol)  
Haldol® Decanoate Injection (haloperidol)  
Pancrease® Capsules (pancrelipase)  
Pancrease® MT Capsules (pancrelipase)  
Paraflex® Caplets (chlorzoxazone)

Parafon Forte® DSC Caplets (chlorzoxazone)  
Tolectin® Capsules and Tablets (tolmetin sodium)  
Tylenol® with Codeine Tablets and Elixir (acetaminophen and codeine phosphate)  
\*Tylox® Capsules (oxycodone hydrochloride and acetaminophen capsules USP)  
Vascor® Tablets (bepridil HCl)

## Ortho Biotech

Procrit® Injection (epoetin Alfa)

## Ortho Pharmaceutical Corporation

Aci-Jel® Therapeutic Vaginal Jelly  
Floxin® Tablets (ofloxacin)  
Micronor® Tablets (norethindrone)  
Modicon® Tablets (norethindrone/ethinyl estradiol)  
Ortho® Dienestrol cream (dienestrol)  
Ortho-Novum® Tablets (norethindrone/mestranol) or (norethindrone/ethinyl estradiol)  
Protostat® Tablets (metronidazole)  
Sultrin® Triple Sulfate Cream and Vaginal Tablets (sulfathiazole/sulfacetamide/sulfabenzamide)

Terazol® Cream and Vaginal Suppositories (terconazole)  
Erycette® Topical Solution (erythromycin)  
Grifulvin V® Tablets/suspension (griseofulvin microsize)  
Meclan® Cream (meclocycline sulfosalicylate)  
Monistat Derm® Cream (miconazole nitrate)  
Persa-Gel® & Persa-Gel® W (benzoyl peroxide)  
Retin-A® Cream/Gel/Liquid (tretinoin)  
Spectazole® Cream (econazole nitrate)

\*Duragesic® and Tylox® (CII controlled substances) will be replaced with other products.



# PHARMACEUTICALS AVAILABLE TO KENTUCKY PHYSICIANS CARE

These Abbott Laboratories and Novo Nordisk pharmaceuticals may be prescribed and dispensed under the program:

## Abbott Laboratories

Biaxin<sup>®</sup> Tablets (clarithramycin)  
Cartral<sup>®</sup> Filmtab<sup>®</sup> Tablets (carbetolol HCl)  
Cylert<sup>®</sup> Tablets C<sup>IV</sup> (pemoline)  
Depakate<sup>®</sup> Sprinkle Capsules (divalproex sodium)  
Depakate<sup>®</sup> Tablets (divalproex sodium delayed-release tablets)  
Enduran<sup>®</sup> Tablets (methyclothiazide tablets, USP)  
Enduranyl<sup>®</sup> Tablets (methyclothiazide and deserpidine)  
E.E.S. 400<sup>®</sup> Filmtab<sup>®</sup> (erythramycin ethylsuccinate tablets, USP)  
E.E.S. Granules (erythramycin ethylsuccinate for oral suspension, USP)  
E.E.S. 200 Liquid (erythramycin ethylsuccinate oral suspension, USP)  
E.E.S. 400 Liquid (erythramycin ethylsuccinate oral suspension, USP)  
Eryderm<sup>®</sup> (erythramycin topical solution, USP 2%)  
Eryped<sup>®</sup> Chewable Tablets (erythramycin ethylsuccinate tablets, USP)  
Eryped<sup>®</sup> Draps (erythramycin ethylsuccinate for oral suspension, USP)  
Eryped<sup>®</sup> 200 (erythramycin ethylsuccinate for oral suspension, USP)  
Eryped<sup>®</sup> 400 (erythramycin ethylsuccinate for oral suspension, USP)  
Ery-Tab (erythramycin delayed-release tablets, USP, enteric-coated)  
Erythracin<sup>®</sup> Stearate Filmtab<sup>®</sup> (erythramycin stearate tablets, USP)  
Erythramycin Base Filmtab<sup>®</sup> (erythramycin tablets, USP)  
Fera-Falic-500<sup>®</sup> Filmtab (controlled-release iron with vitamin C and folic acid)  
Fera-Gradumet<sup>®</sup> Filmtab (controlled-release dose of iron)  
Hytrin<sup>®</sup> Tablets (terazosin hydrochloride tablets)  
Iberet<sup>®</sup> Filmtab<sup>®</sup> (controlled-release iron, vitamin C and B-complex vitamins)  
Iberet<sup>®</sup>-500 Filmtab<sup>®</sup> (controlled-release iron with vitamin B-complex and vitamin C)  
Iberet-Falic-500<sup>®</sup> Filmtab<sup>®</sup> (controlled-release iron with vitamin C and B-complex vitamins including folic acid)  
Iberet<sup>®</sup>-Liquid Oral Suspension (iron, B-complex vitamins and vitamin C)

Iberet<sup>®</sup>-500 Liquid Oral Solution (iron, B-complex vitamins and vitamin C)  
K-Lar<sup>®</sup> 20 mEq. Powder Packets (potassium chloride for oral suspension, USP)  
K-Lar<sup>®</sup> 15 mEq. Powder Packets (potassium chloride for oral suspension, USP)  
K-Tab<sup>®</sup> 10 mEq. (750 mg.) (potassium chloride extended-release tablets, USP)  
Ogen<sup>®</sup> Vaginal Cream (estropipate vaginal cream, USP)  
Ogen<sup>®</sup> .625 Tablets (estropipate tablets, USP)  
Ogen<sup>®</sup> 1.25 Tablets (estropipate tablets, USP)  
Ogen<sup>®</sup> 2.5 Tablets (estropipate tablets, USP)  
PCE<sup>®</sup> 333 mg. Tablets (erythramycin particles in tablets)  
PCE<sup>®</sup> 500 mg. Tablets (erythramycin particles in tablets)  
Prasam<sup>®</sup> Tablets C<sup>IV</sup> (estazolam tablets)  
Surbex<sup>®</sup> Filmtab<sup>®</sup> (vitamin B-complex)  
Surbex<sup>®</sup> with C Filmtab<sup>®</sup> (vitamin B-complex with vitamin C)  
Surbex-T<sup>®</sup> Filmtab<sup>®</sup> (high-potency vitamin B-complex with vitamin C)  
Surbex<sup>®</sup> 750 with Iron Filmtab<sup>®</sup> (high-potency B-complex with iron, vitamin E and 750 mg. of vitamin C)  
Surbex<sup>®</sup> 750 with Zinc Filmtab<sup>®</sup> (zinc, vitamin B-complex and vitamins C and E)  
VI-Daylin<sup>®</sup>/F Multivitamin Chewable Tablets  
VI-Daylin<sup>®</sup>/F Multivitamin + Iron Chewable Tablets  
VI-Daylin<sup>®</sup> Multivitamin Chewable Tablets  
VI-Daylin<sup>®</sup> Multivitamin + Iron Chewable Tablets  
VI-Daylin<sup>®</sup> Multivitamin Draps  
VI-Daylin<sup>®</sup> ADC Vitamins Draps  
VI-Daylin<sup>®</sup>/F Multivitamin Draps  
VI-Daylin<sup>®</sup>/F ADC Vitamins Draps  
VI-Daylin<sup>®</sup> Multivitamin plus Iron Draps  
VI-Daylin<sup>®</sup> ADC Vitamins plus Iron Draps  
VI-Daylin<sup>®</sup>/F Multivitamin plus Iron Draps  
VI-Daylin<sup>®</sup>/F ADC Vitamins plus Iron Draps  
VI-Daylin<sup>®</sup> Multivitamin Liquid  
VI-Daylin<sup>®</sup> Multivitamin plus Iron Liquid

## Novo Nordisk

### HUMAN INSULIN (recombinant DNA origin)

Navalin<sup>®</sup> R  
Navalin<sup>®</sup> L  
Navalin<sup>®</sup> N  
Navalin<sup>®</sup> 70/30  
Navalin<sup>®</sup> R PenFill<sup>®</sup>  
Navalin<sup>®</sup> N PenFill<sup>®</sup>  
Navalin<sup>®</sup> 70/30 PenFill<sup>®</sup>

### HUMAN INSULIN (semi-synthetic)

Velasulin<sup>®</sup> Human  
Insulatard<sup>®</sup> Human  
Mixtard<sup>®</sup> Human 70/30

### PURIFIED INSULIN

Regular-R  
Lente<sup>®</sup> L  
NPH-N  
Velasulin<sup>®</sup> R  
Insulatard<sup>®</sup> N  
Mixtard<sup>®</sup> 70/30

### STANDARD INSULIN

Regular-R  
Lente<sup>®</sup> L  
NPH-N  
Semilente<sup>®</sup> S  
Ultralente<sup>®</sup> U

# PARTICIPATING PHARMACIES

## KPC PHARMACY PROVIDER PROGRAM

**Adair**  
DBA Columbia Pharmacy  
Madison Square Drugs & Chymist

**Allen**  
Carpenter Dent Drugs  
Stovall Prescription Shop  
Williams Pharmacy

**Anderson**  
The Medicine Shoppe  
Reliable Drugs

**Ballard**  
Wickliffe Pharmacy, Inc

**Barren**  
Ely Drugs, Inc  
Glasgow Prescription Center  
K-Mart Pharmacy  
Tawne & Cauntry Drugs

**Bell**  
City & County Drug  
Farris Drugs  
Jeff's Pharmacy  
K-Mart Pharmacy  
Kroger Campony  
Pineville Hos. Out-Pt Pharmacy  
Rxca Friendly Pharmacy  
SuperX Drugs  
Total B. Care Pharmacy

**Boone**  
Boone County Drugs  
Burlington Pharmacy  
K-Mart Pharmacy  
SuperX Drugs  
Turfway Pharmacy

**Bourbon**  
Glen's Drugs  
Horne's Ardrey Drug  
The Medicine Shoppe

**Boyd**  
K-Mart Pharmacy  
Laynes Pharmacy  
McMeans Pharmacy  
Reliable Drugs  
SuperX Drugs

**Boyle**  
Grider Pharmacy  
K-Mart Pharmacy  
Leake Pharmacy  
SuperX Drugs  
Taylor Drug

**Bracken**  
Dean's Pharmacy

**Breathitt**  
Jackson Prescription Ctr  
Reliable Drugs

**Breckinridge**  
Save-Rite Drugs  
Towne & Cauntry Pharmacy

**Bullitt**  
Taylor Drugs

**Caldwell**  
Payless Discount Pharmacy  
The Pharmacy Corner Enterprise

**Callaway**  
Clinic Pharmacy  
Holland Drugs  
Reliable Drugs  
Safe-T Discount Pharmacy  
Walter's Pharmacy

**Campbell**  
Alexandria Drugs  
Martin's Pharmacy  
Newport Drug Center  
SuperX Drugs

**Carlisle**  
Arlington Pharmacy, Inc

**Carroll**  
Parklane Pharmacy  
Webster Drugs

**Carter**  
Hartan Brather & Brown  
K-Mart Pharmacy  
Rose Pharmacy

**Christian**  
Express Pharmacy  
Harn Prescription Shop  
Jennie Stuart Medical Center  
Reliable Drugs  
Save More Drug  
The Medicine Shoppe

**Clark**  
Carner Drug Store  
Day Drugs  
K-Mart Pharmacy  
Reliable Drugs  
SuperX Drugs

**Cloy**  
Family Drug Center  
H & N Drug  
Medi Center Drugs

**Crittenden**  
Glenn's Apothecary

**Cumberland**  
Smith Pharmacy

**Daviess**  
Danhaver Drug Company  
Emery Centre Pharmacy  
Greene's Pharmacy  
Harreld's Drug Store  
Mayfair Pharmacy  
Medical Plaza Pharmacy  
Medicine Shoppe  
Nation's Medicines  
Reliable Drugs  
Taylor Drug #21  
Wal-Mart Pharmacy  
Whitesville Drug Store

**Edmanson**  
Prescription Shop

**Fayette**  
Hi-Acres Pharmacy  
Hubbard & Curry Pharmacy  
Hutchinson Drug  
K-Mart Pharmacy  
All Kroger Pharmacies  
Professional Arts Apothecary  
Randall's Pharmacy  
Taylor Drugs  
The Medicine Shoppe  
U of Ky Chandler Medical Center  
Warehouse Drugs  
Woodhill Pharmacy

**Fleming**  
Plaza Pharmacy

**Floyd**  
Archer Clinic Pharmacy  
Betsy Layne Pharmacy  
Brooks Pharmacy, Inc  
Mud Creek Clinic Pharmacy  
Our Lady Of The Way Hospital

**Franklin**  
East Side Pharmacy  
Fitzgerald Drugs  
K-Mart Pharmacy  
Kroger Pharmacy  
Medicine Shoppe  
Reliable Drugs  
Taylor Drugs  
The Prescription Center

**Fulton**  
City Super Drug  
Evans Drug Company  
Rumfelt Drug  
SuperX Drugs

**Garrard**  
Sutton Pharmacy

**Grant**  
Grant County Drugs

**Graves**  
K-Mart Pharmacy  
Stanes Drugs  
SuperX Drugs  
Wilson Rexall Drugs

**Grayson**  
Clarkson Drug Store  
Reliable Drugs

**Green**  
Model Drug Store

**Greenup**  
Reliable Drugs  
Scott Drugs  
Stultz Pharmacy

**Hardin**  
Jeff's Prescription Shop  
K-Mart Pharmacy  
Kroger Company  
Lincoln Trail Pharmacy  
Radcliff Drugs  
Showers & Hays Drugs  
SuperX Drugs  
Taylor Drugs  
Woolridge Drug

**Harlan**  
Lynch Med. Services Pharmacy  
SuperX Drugs

**Harrison**  
Eastside Pharmacy Of Cynthiana  
Lee Drugs

**Hart**  
Branstetter Pharmacy  
Clarks  
Mallory Drugs

**Henderson**  
Dunaway's Imperial Pharmacy  
Family Pharmacy North  
Family Pharmacy South  
K-Mart Pharmacy  
Reliable Drugs  
T & T Drugs

**Henry**  
Cook's Pharmacy

**Hickman**  
Perkins Pharmacy

**Hopkins**  
Earlington Pharmacy  
Family Drugs  
Madisonville Pharmacy  
Nation's Medicines  
Professional Drugs #2  
Reliable Drugs  
SuperX Drugs

**Jackson**  
Annville Pharmacy  
Campbell's Drug  
Clinic Pharmacy  
Rite Aid #3270

**Jefferson**  
Alliant Health System Pharmacy  
Applied Pharmacy Therapeutics  
Art Jacob Prescription Shoppe  
Band Pharmacy  
Colonial Drugs  
Cax's Pharmacy  
Cax's Pharmacy #1  
DBA Hametek Pharmacy  
Harding Pharmacy  
Haldaway Drugs  
Hume Pharmacy  
K-Mart Pharmacy  
Kaby Drug Company  
All Kroger Pharmacies  
Oak Drug Company, #1  
Parrina Pharmacy  
Rauben's Pharmacy  
St. Denis All Care  
All SuperX Drugs  
All Taylor Drugs  
U of L Hospital Ambulatory Care  
Pharmacy  
Union Prescription Center  
Wal-Mart Pharmacies  
Warehouse Drugs

**Jessamine**  
Drug Mart  
Medicine Shoppe  
Taylor Drugs



# PARTICIPATING PHARMACIES

## KPC PHARMACY PROVIDER PROGRAM

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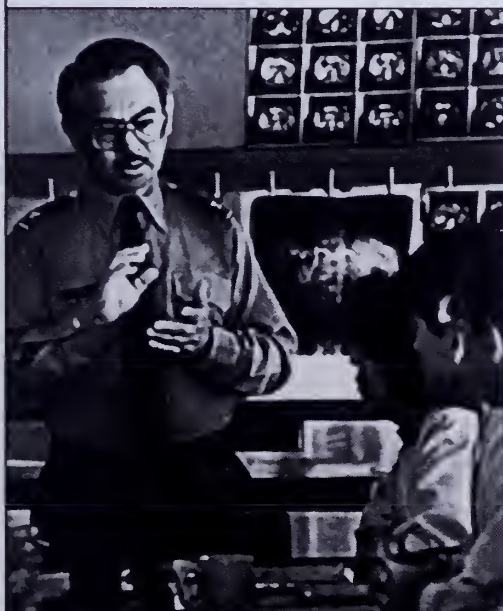
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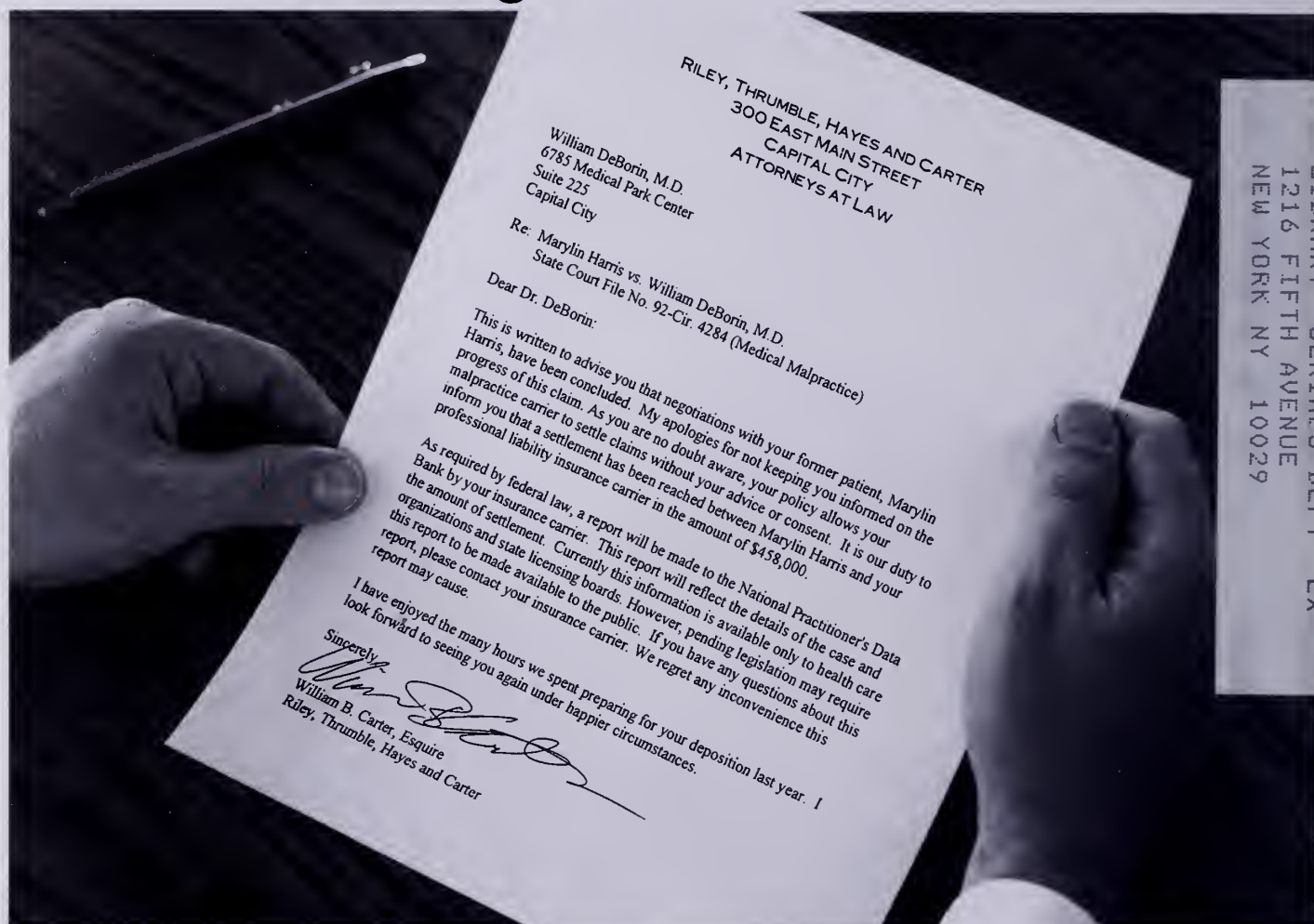
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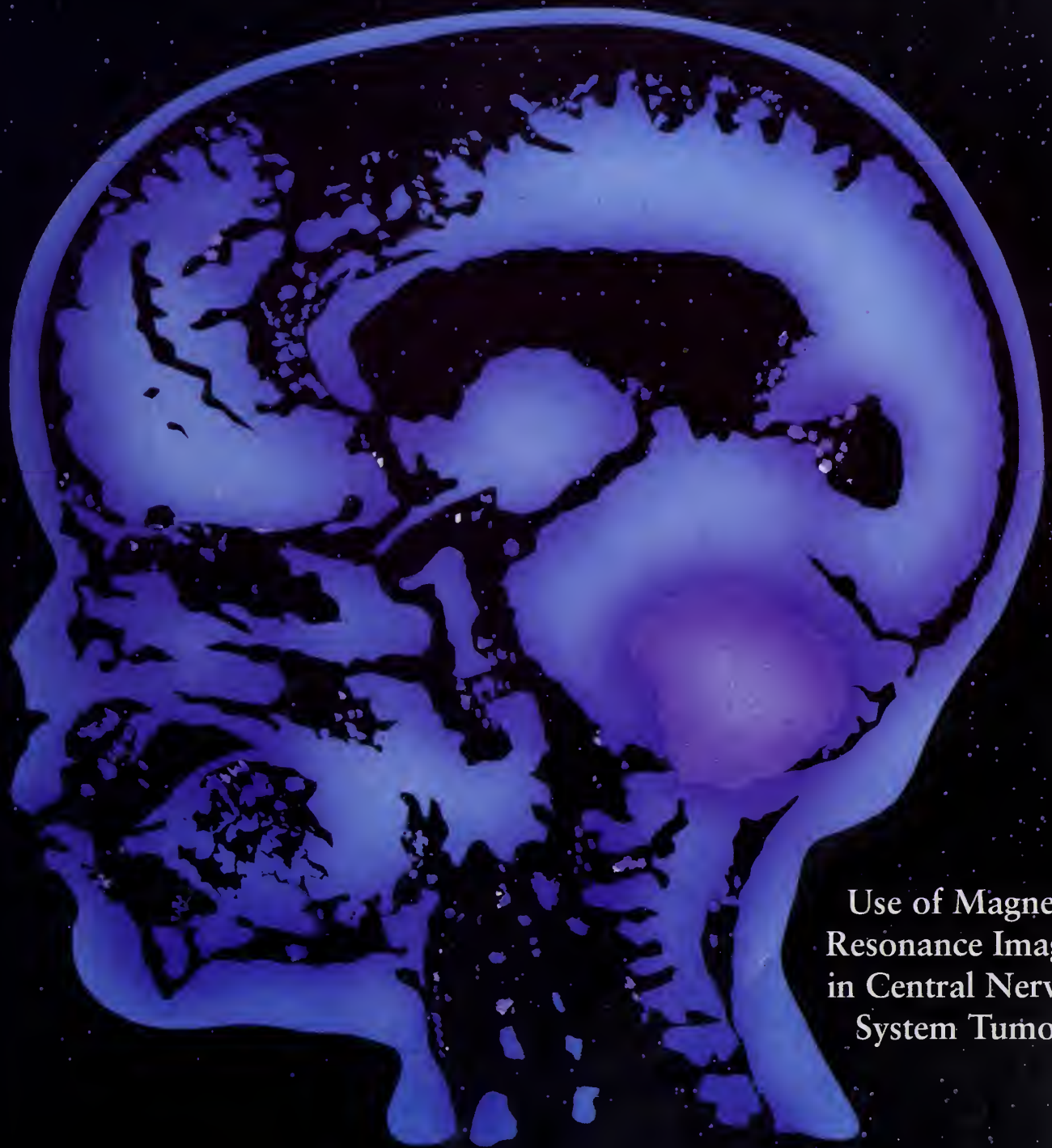
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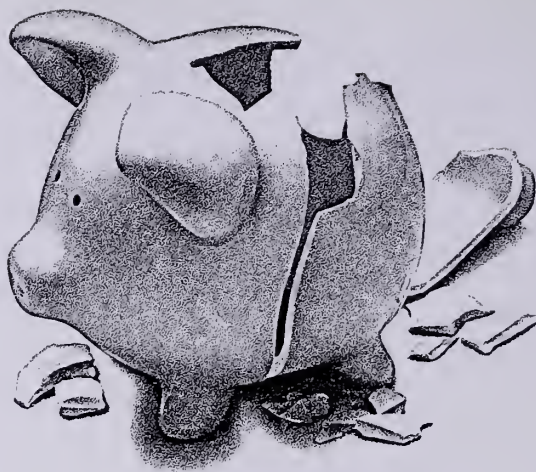
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Use of Magnetic  
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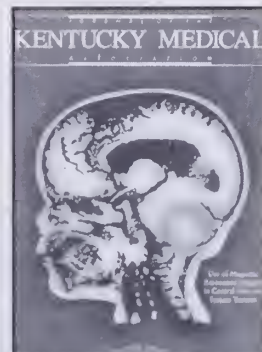
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VOLUME 93, NUMBER 3

MARCH 1995

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**COVER:** Confirming that Magnetic Resonance Imaging provides important additional information for radiation therapy planning is the basis for this month's cover article. See page 88. Artwork by Lee Wade of Louisville.

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# Minding Our Business

The provider tax, Medicaid cuts, and oppressive sections of House Bill 250 continue. President Bob Goodin calls them the "triple whammy." But we're not throwing up our hands. We are countering with our own "triple whammy" which includes physician and patient education, political involvement, and legislative strategy.

In 1993, the KMA House of Delegates authorized a patient education campaign which the Board placed under the direction of Preston Nunnelley, MD. The committee has developed a long-term patient education campaign to enlighten our patients on matters of mutual concern, particularly barriers which obstruct or impede physician/patient relationships. Newsletters, tapes, speeches, and press releases have been produced. The committee is also preparing an education campaign directed toward legislators. Bumper stickers (25,000) have been mailed to all Kentucky physicians which state simply, "**Repeal the Tax.**" You will soon receive packets which will include patient brochures and "talking points" to assist in writing letters and contacting legislators. We will also provide samples and "talking points" so that you can communicate to legislators who **supported** KMA's position and legislators who **opposed** KMA and voted for the tax, House Bill 250, and Medicaid cuts. In addition, we plan to provide sample letters which patients may use if they ask to support our position.

Public relations activity will

increase at a rapid pace in the latter part of 1995 and continue through the 1996 Session. Various media outlets will be utilized to tell our story. However, because these issues will not be considered until January '96, we don't want our campaign to peak too early.

Secondly, Bill VonderHaar, KEMPAC chair, has appointed an Ad Hoc Committee led by Bill Monnig, MD, which has been assigned the task of rewriting KEMPAC goals and objectives. Recent changes in state law restricts campaign contributions, so KEMPAC is exploring other areas in which they can get involved and be effective. You can expect the goals to include voter registration, political education, defeating, or electing public officials who share or do not share our philosophy, and the need of physicians, their families, and their staffs to get involved in politics.

Thirdly, the KMA legislative effort, under the able leadership of Wally Montgomery, is already at work. The Committee is preparing legislation and obtaining sponsors for the 1996 General Assembly. You recently received a letter from President Bob Goodin urging involvement in the gubernatorial campaign. Your participation is crucial! Our goal is to assure that every candidate for Governor supports our objectives. KMA will also be meeting with candidates and will report the results to you. Every county needs to establish a legislative committee. KMA officers and staff are available to assist your local efforts.

We can and will succeed



*Donald R. Stephens, MD*

provided **YOU DO YOUR PART.** We need your constructive criticism and suggestions. I have been astonished with the support you have provided and the willingness to do what is necessary to rid our patients and the profession of the Clinton-Jones health plan commonly referred to as HB 250. What we don't need, at this juncture, are critics running around creating divisiveness and pressing their personal agendas. We all have problems with the mess created in 1994. We need to remain unified. We have the support of most major gubernatorial candidates to repeal the provider tax. Support is also building to seriously address the Medicaid crisis.

I have supported every lawsuit KMA has filed. We were compelled to challenge the constitutionality of the provider tax **and we did — first — long before anyone else even considered a lawsuit** and, secondly, we aggressively took on the Governor and Secretary of CHR over the unconscionable Medicaid cuts. That fight will continue for as long as it takes. If the Governor tries to force us



to accept DOP patients, we will take that issue to the courts in a heartbeat. However, I feel the need to be candid. We can sue till hell freezes over, but I don't believe we will ever find support in the courts. Courts rarely support doctors.

Above all — don't kid yourself — this fight is not our patients' fight. People don't lose sleep if doctors are taxed. They might worry about the price of bread or gasoline, but their concern for taxes on doctors and their incomes fall way down their list of priorities. So don't hold your breath waiting for patients to contact legislators. It's your fight to win or lose. Our victory over the tax, restoring the Medicaid cuts, and repealing burdensome sections of House Bill 250 will take place where defeat occurred — in the halls and chambers of the state capitol and the Kentucky General Assembly. **The Governor and the legislature created the problem. A new Governor and a new legislature can correct the problem.**

#### So, what can you do?

1. Join KEMPAC. It's the best \$100 you'll ever spend. It is the only political action committee in Kentucky representing physicians. **If ever your support was needed — now is the time.**

2. Contact your state representative and senator. Seek their commitment, support, and agreement to cosponsor our legislation. **If they refuse or offer flimsy explanations or excuses, remember them in '96.**

3. Meet or write the gubernatorial candidates. Find out what their positions are on medical issues. **If they support you, support them. If they don't, work against them.**

4. **Get out your checkbook.** \$500.00 is the maximum contribution allowed. For the first time, you can have an impact — a voice. Recognizing the fact that candidates on both sides of the aisle are supporting our position on the tax and Medicaid, some physicians are supporting more than one candidate — big industry has been doing this for years — so why can't we?

5. **Organize a local legislative committee.** Prepare for the 1996 Session by holding society meetings featuring local legislators. Invite KMA officers or staff to address the society or work with the committee.

6. **Appoint a local PR committee** to meet with newspaper editors, radio and TV executives to explain physicians points of view.

Remember — we lost the provider tax in 1994 by one vote in the Senate and 13 votes in the House. In 1996, 100 of 100 representatives and 19 of 38 senators face the

electorate. However, every single one of them will vote on those issues of concern to the medical community before they face the electorate. We have the political will and the political stamina to turn Frankfort upside down. We can and will prevail if each of you use your energies and resources wisely.

We have 10 months to prepare for the 1996 Session. Many of our county medical societies and individuals are already working with their legislators and conducting local public relations campaigns. The grass roots effort in these counties offers a stark contrast to the traditional physician image of "political avoidance." Physicians and spouses understand that political activity is as important to their practice and future as other phases of professional and community life. The unfair political and written media assault upon physicians will continue — unabated — susceptible only to an equally aggressive physician community protecting their rights, their profession, and above all, their patients. As in Pericles from ancient Athens: *"Every individual has a role to play. We say here that a man who is not interested in politics is not minding his own business."*

**Donald R. Stephens, MD**  
Chair, KMA Board of Trustees

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While we can interpret our contract, state law does not allow us to interpret the contract(s) of others. Please seek the advice of your personal attorney as the best source for review of third party contracts. We hope this clarification of our policy will help you in managing your practice. Please feel free to contact your General Agent at (800) 344-1899.

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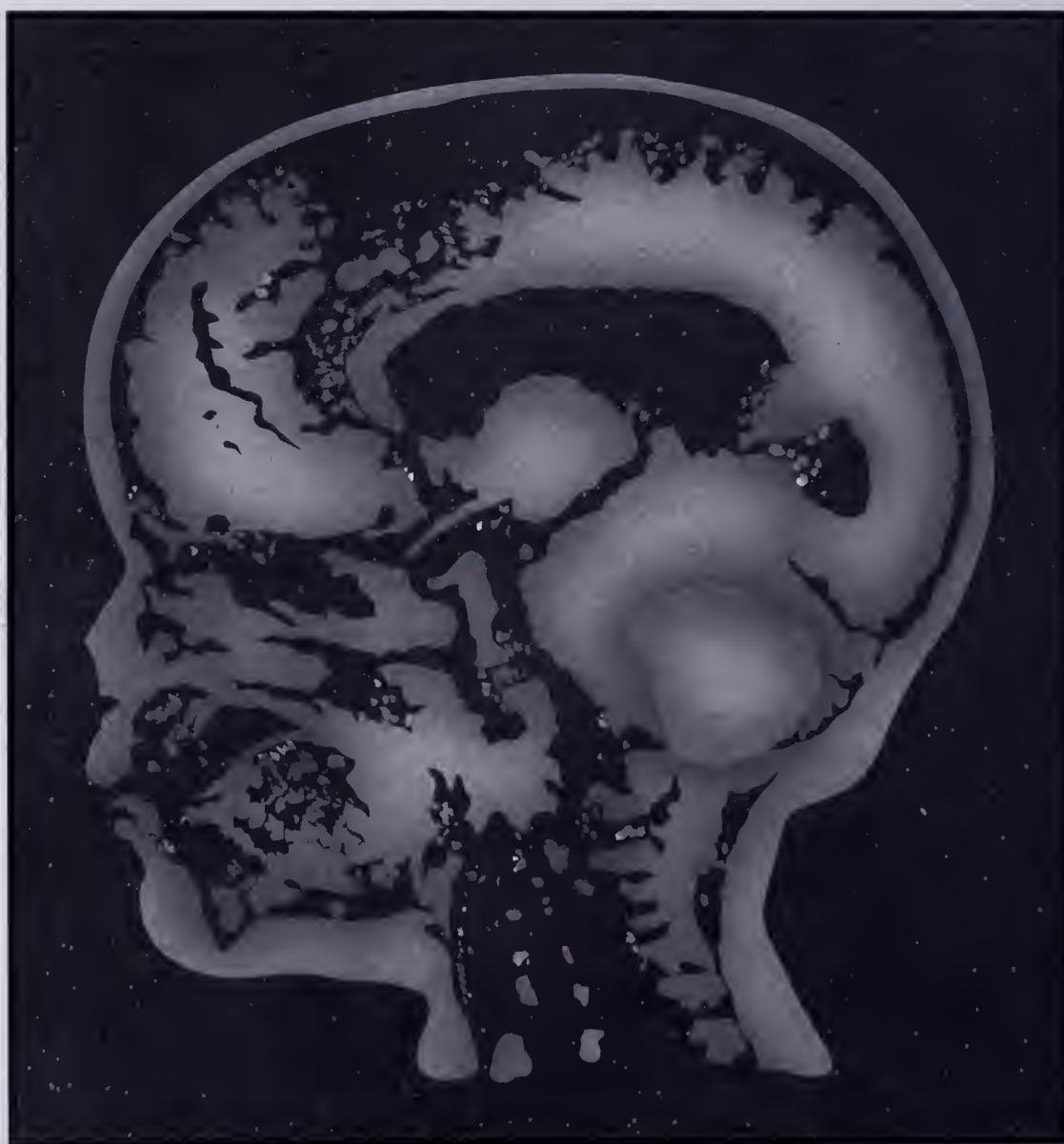
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# Use of Magnetic Resonance Imaging in Central Nervous System Tumors

*Baby Jose, MD; Robert Lindberg, MD; William Spanos, Jr, MD; Kristie Paris, MD*



MRI provides additional information about tumor location, extent, and margins. MRI was used in 158 patients with CNS tumors for treatment planning from 1985-89 and they were studied in a prospective manner. The most common site was cerebrum (73 pts), then extradural spinal axis (21 pts) posterior fossa (17 pts), brain stem (14 pts) and pituitary (13 pts), etc. The most common histological primary tumor was glioblastoma multiform (25 pts), then low grade astrocytoma (22 pts), anaplastic astrocytoma (14 pts), pituitary tumor (13 pts), medulloblastoma (9 pts), ependymoma (7 pts), and germ cell tumors (6 pts). Twenty-nine patients had metastasis to the brain. A majority of the patients with CNS tumors had the studies using Gadolinium-DTPA. Of the patients with CNS tumors, 120 (76%) had better information based on the MRI, which improved the treatment planning (using the three dimensional images) and field arrangement. In 89 patients (56%) the MRI was very decisive in the treatment volume and field arrangement. In 31 patients (20%) the MRI was beneficial and confirmed the treatment plan. MRI provides important additional information for radiation therapy planning.

The importance of Magnetic Resonance Imaging (MRI) in evaluation of tumors, especially in the central nervous system, has been established in recent years.<sup>1-19</sup> In radiation oncology precise localization of the tumor is critical when attempting to give sufficient radiation dose to the tumor while minimizing radiation to the surrounding normal tissue. Proper radiation doses to the tumor can reduce the local recurrence, and limiting the volume of normal tissue in the radiation fields can reduce the risk of complications. The aim of this study was to analyze the effect of MRI in radiation oncology in CNS tumors, in tumor volume estimation using the three dimensional images, and in field arrangements for irradiation.

### Materials and Methods

This study included 158 patients with CNS tumors in whom MRI was used in treatment evaluation from 1985-1989. The images were performed on 1.5 Tesla scanners (Philips-Gyrosan, General Electric-Signa). Both T<sub>1</sub> and T<sub>2</sub> weighted sequences were obtained with combinations of repetition times (TR of 600, 800, 1000, 2000 msec) and echo times (TE of 40, 60, 80 msec). All studies

were acquired by multisection, single-echo, or multi-echo methods. The display matrix was 256 × 256. Images were displayed in transverse, coronal, and sagittal planes. A majority of the patients with central nervous system (CNS) tumors had enhanced studies using Gadolinium-DTPA (0.1 mmol/kg of body weight), which was helpful to delineate the tumor from normal tissues and surrounding oedema. Examples of some of the tumors are depicted in Figs 1-5.

Of 158 patients with CNS tumors, cerebrum (73) and extradural spinal axis (21) were the common sites (Table 1). Table 2 depicts the different histological types of tumors in the CNS. Of primary tumors of the CNS, Glioblastoma multiform (25) and low grade astrocytoma (22) constituted 30% of the patients.

**Table 1. Tumor Sites in Central Nervous System**

Tumor site	Number of Patients	Percent
Cerebrum	73	46
Extra dural/ spinal axis	21	13
Posterior fossa	17	11
Brain stem	14	9
Pituitary	13	8
Pineal region	7	4
Optic region	4	3
Cerebellum	3	2
Thalamic region	3	2
Meninges	3	2
TOTAL	158	100

**Table 2. Tumor Histology in Central Nervous System**

Histology	Numbers of Patients	Percent
Metastasis to brain	29	18
Glioblastoma multiform	25	16
Low grade (I & II) astrocytoma	22	14
Extradural metastasis	20	13
Anaplastic (grade III) astrocytoma	14	9
Pituitary adenoma	13	8
Medulloblastoma	9	5.5
Ependymoma	7	4
Germ cell tumor	6	4
Primitive neuroectodermal tumor (PNET)	4	2.5
Lymphomas	3	2
Meningiomas	3	2
Optic gliomas	3	2
TOTAL	158	100

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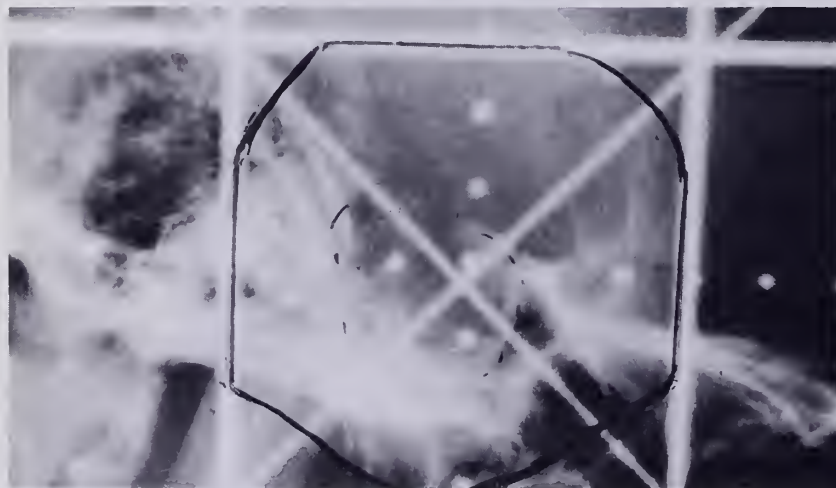
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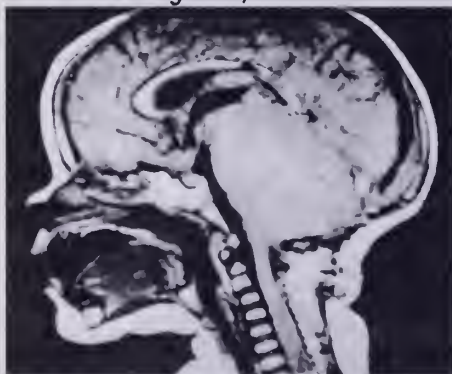
## Use of MRI in CNS Tumors



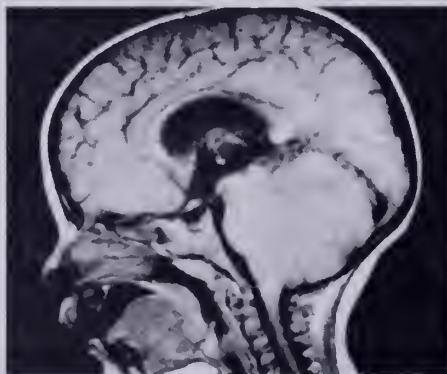
**Fig 1 —** Sagittal MRI image of pituitary tumor.



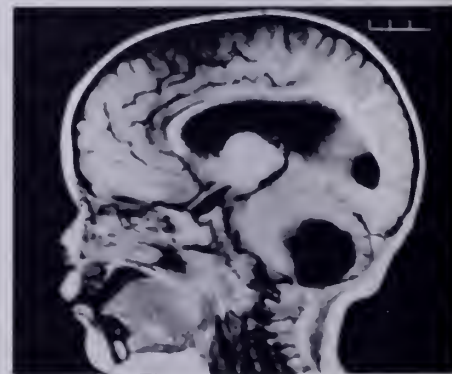
**Fig 2 —** Field arrangement for pituitary tumor, using custom blocks (Lateral view of the 3 field arrangement).



**Fig 3 —** Large medulloblastoma of the posterior fossa with upward extension.



**Fig 4 —** Large astrocytoma of the cerebellum, before surgery.



**Fig 5 —** Residual tumor after subtotal resection of the astrocytoma before irradiation.

The benefit of MRI was assessed in volume estimation and field arrangement. The benefit was scored in a prospective manner in each case. The scoring was done from 1-3 (1-no additional benefit by MRI; 2-MRI was beneficial in field arrangement and confirms the plan; 3-MRI was very decisive in field arrangement and volume estimation for the treatment fields). The treatment planning and the dosimetry were assisted using a dedicated General Electric 8800 CT scanner and General Electric (Target) Computerized treatment planning unit. Patients with primary tumors and selected patients with metastasis were treated with custom made blocks.

### Results

Of 158 patients with CNS tumors, 120 (76%) had beneficial effect with MRI in detailed information for volume estimation and field arrangement. In 89 patients (56%) the benefit was scored as 3 where MRI was very decisive in the treatment volume and field arrangement. In 31 patients (20%) the benefit was scored as 2 where MRI was beneficial and confirmed the treatment plan. All three dimensional images were useful in volume estimation. This was an advantage compared to Computerized Axial Tomography (CAT) images. Patients who were treated with parallel opposed tailored fields had the maximum benefit from the sagittal images. In patients with small central tumors such as pituitary adenomas, which were treated with 3 field arrangement, the MRI improved accuracy and confidence in the treatment planning. Use of Gadolinium-DTPA enhanced images in almost all patients, which helped to make the boost fields more accurate since the tumor

margin was defined more clearly from the surrounding tissues. Tumors of the posterior cranial fossa and brain stem region were better defined by MRI due to absence of bony artifacts as seen in CAT scans of those regions.

## Discussion

Inaccurate localization of tumors can cause underdosing to the tumors and/or excessive dose to normal tissues. There are many recent reports showing the benefit of MR studies in volume estimation, field arrangements, use of Gd-DTPA, delayed effects of irradiation, differentiation between recurrence, and fibrosis and spectroscopy.<sup>1-19</sup> MRI provides more information regarding tumor presence and extension due to better soft tissue contrast and multiplanary acquisition. Accurate volume estimation is possible with three dimensional images by MRI, which is beneficial in external as well as interstitial irradiation. In an earlier study, additional information obtained from MRI caused changes in the field arrangement in 53% (16/30 patients) and confirmed the existing plan of treatment in 71% (10/14 patients) of studied patients.<sup>16</sup> The benefits of MRI are greater in tumors of posterior fossa, brain stem, and spinal axis. In the current study, 76% (120/158) of patients had beneficial effect using MRI.

Gd-DTPA will accumulate where the blood brain is deficient and shortens the MR relaxation times directly in proportion to its local concentrations. Tumors that enhance at post contrast CT examination will also enhance at Gd-DTPA MR studies.<sup>1,10</sup> Also, Gd-DTPA enhancement will help detection of small metastasis and visualization of additional lesions in cases of suspected solitary metastatic lesion.<sup>1</sup> In the present study using Gd-DTPA, tumors were better defined from surrounding tissues.

The advantages of MRI over CT scans are many fold. They include (1) three dimensional images of the lesions; (2) better definition of the lesions in the posterior fossa and brain stem areas due to less scatter from bony parts; (3) detection of smaller or multiple lesions by MRI due to higher resolution; (4) no effect of irradiation in multiple examinations, especially in children; (5) clinical use of noninvasive magnetic resonance arteriography; (6) use of magnetic resonance spectroscopy in diagnosis and follow-up of CNS lesions. The major drawback of MRI is the current cost of the procedure; however, with fast scans, the cost is expected to decrease.

In summary, use of MRI in patients with CNS tumors is beneficial in a majority of patients in volume estimation and field arrangement. Use of Gd-DTPA enhancement helps to define the tumors from surrounding tissues. The effects on the white matter from radiation is currently being evaluated using MRI. We are also planning to study the clinical outcome regarding local control and survival in patients with primary CNS tumors, who had MRI as part of their evaluation.

ACKNOWLEDGMENTS: The authors gratefully acknowledge Cheryl Bickel for preparing this manuscript.

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# Polymyositis Associated with Primary Biliary Cirrhosis

William G. Simpson, MD; Nicholas J. Nickl, MD

**P**imary biliary cirrhosis (PBC) is commonly associated with disorders of other organ systems, approaching 100% in some series.<sup>1</sup> Connective tissue diseases (scleroderma, Sjögren's syndrome, arthropathy) are most common<sup>1,2</sup> (Table 1). The prevalence of such associated disorders may support a suggested autoimmune etiology of PBC. Polymyositis, however, has been rarely reported in association with PBC.

## Case Report

A 27-year-old woman complaining of pruritus and mild fatigue was referred for evaluation. Following the diagnosis of PBC in a sister, an antimitochondrial antibody was detected at a titer of 1:640. The patient denied weakness, arthralgias, or skin rash. The exam revealed no stigmata of chronic liver disease, and was otherwise normal. The liver chemistries were normal (Table 2). A percutaneous liver biopsy specimen demonstrated changes consistent with stage I PBC, and colchicine was begun. Approximately 8 months later the patient complained of dramatically worsening proximal muscle weakness, which she distinguished from her persistent fatigue. Proximal muscle weakness was confirmed on exam, and no skin rash was present. An elevated creatinine kinase prompted discontinuation of the colchicine, but there was no clinical improvement. Thyroid studies were normal. Electromyography demonstrated myotonic discharges, fibrillation potentials, and changes in the motor unit potential, consistent with a primary myopathic process. Nerve conduction studies were normal. Muscle biopsy demonstrated necrotic and degenerating muscle fibers, supportive of a diagnosis of polymyositis. Therapy with prednisone 40 mg twice daily resulted in improvement of muscle strength with gradually declining markers of muscle damage (Table 2).

## Discussion

Connective tissue and autoimmune diseases have

a known association with PBC.<sup>1,2</sup> The inflammatory myopathy polymyositis has rarely been reported in association with PBC, however. Sherlock and Sheuer<sup>3</sup> reported a single patient with dermatomyositis among their series of 100 patients with PBC. Uhl et al<sup>4</sup> reported the development of scleroderma and polymyositis in a patient with PBC. Of 93 patients with PBC reviewed by James et al,<sup>5</sup> one had associated polymyositis. An additional case was described by Willson.<sup>6</sup>

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**Table 1.** Disorders Associated with Primary Biliary Cirrhosis\*

Disorder	Incidence
Sjögren's Syndrome	70-100%
Scleroderma	15-20%
Raynaud's	7%
CREST	2-16%
Inflammatory Arthropathy	4-50%
Thyroiditis	6-17%
Renal Tubular Acidosis	33-60%
Celiac disease	20%
Breast Cancer	**

\* References 1 and 2.

\*\* Reported four-fold increase risk among patients with PBC.

**Table 2.** Laboratory Findings in Polymyositis Associated with PBC.

Time@	AST/ALT*	AP/GGT*	TB*	CK*	Aldolase*
0	32/36	108/144	0.6	136	
3	117/179	157/57	0.8	128	
8	144/165	108/26	0.9	5085†	
9	Colchicine Discontinued 102/105	98/-	0.7	4415	33.4
	Steroids Initiated				
10	58/131	100/36	0.8	949	24.2
15	36/40	90/21	0.6	700	

@ In months from diagnosis

\* Normal values: AST 13-35 U/L, ALT 7-35 U/L, Alkaline Phosphatase (AP) 30-100 U/L, GGT 10-50 U/L, Total Bilirubin (TB) 0.2-1.1 mg/dl, creatinine kinase (CK) 25-170 U/L, Aldolase 0.0-8.0 U/L.

† CK 96% MM isoenzyme.



## Polymyositis Associated with PBC

The onset of myositis in this patient was heralded by an increase in the serum transaminases, a finding uncharacteristic for PBC. Only later were the creatinine kinase and aldolase elevated (Table 2). Further, the weakness reported by the patient differed distinctly from the fatigue which previously limited her activity and is so common in PBC.

Polymyositis is characterized by symmetric proximal muscular weakness with an abnormal elevation of muscle derived enzymes in the serum.<sup>7</sup> The diagnosis is supported if the electromyogram demonstrates appropriate myopathic changes. Muscle biopsy findings vary, and may be initially normal. Approximately 50% of biopsies demonstrate the complete spectrum of findings reported in polymyositis.<sup>7</sup>

Other myopathies, both primary and secondary, should be excluded. Autoimmune thyroiditis develops in 6% to 17% of patients with PBC<sup>3,5</sup> and both hyperthyroidism and hypothyroidism can result in a myopathy clinically similar to polymyositis.<sup>7</sup> Thus, when myopathy is suspected in a patient with PBC, thyroid dysfunction should be excluded. Colchicine has been demonstrated to improve biochemical markers of liver disease in PBC and reduces the risk of death from liver failure.<sup>8</sup> Neither symptoms nor histologic progression of PBC are altered by colchicine, however. Uncommonly, colchicine can induce a myopathy,<sup>9</sup> and should also be excluded in patients receiving this agent. Proximal weakness and elevated serum creatinine kinase levels are associated with polyneuropathy demonstrable upon nerve conduction studies in colchicine neuromyopathy. No such neuropathy was found in our patient. Improvement in strength and normalization of creatinine kinase activity occurs within 4 to 6 weeks after discontinuation of the colchicine if myopathy is due to the drug.<sup>9,10</sup> The incidence of colchicine-induced myopathy among patients with PBC receiving the drug is not well defined. Among four trials of colchicine in PBC, including 92 patients on active therapy, no report of drug-induced myopathy appears.<sup>11-15</sup>

Exogenous steroids remain the drug of choice in polymyositis.<sup>7</sup> High dose steroids result in improvement of strength and normalization of serum enzyme levels over a few months. Patients refractory to steroids, in whom the diagnosis is secure, may benefit from immunosuppressive agents such as azathioprine, methotrexate, or cyclophosphamide.<sup>16</sup> Steroid use in PBC has been associated with little improvement in the liver dis-

ease at the expense of accelerating bone loss and should be approached with caution.<sup>8</sup> Liver transplantation and subsequent immunosuppression for PBC would be expected to result in improvement in concurrent polymyositis, but this has yet to be documented. While the 5-year survival in polymyositis approaches 80%,<sup>7</sup> no data are available on prognosis when associated with PBC.

In summary, a case of polymyositis associated with PBC has been described, bringing the total reported to date to five. While not as common as other connective tissue disorders, an association between PBC and polymyositis appears genuine.

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# Transjugular Intrahepatic Portosystemic Stent Shunt: Nonsurgical Therapy for Portal Hypertension

Philip C. Trover, MD

*The Transjugular Intrahepatic Portosystemic Stent Shunt (TIPSS) is a new, nonsurgical method of lowering portal venous pressure. The procedure is discussed and described, and two cases are presented.*

morbidity (encephalopathy) due to hepatic ischemia.<sup>6</sup> The TIPSS shunt is readily accessible for recanalization if stenosis or occlusion occurs.

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## Summary of Procedure

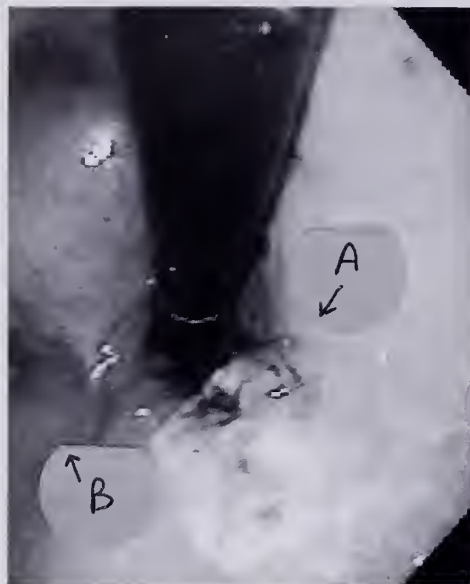
The TIPSS procedure is performed in the angiography suite utilizing intravenous sedation, local anesthesia, prophylactic antibiotics, and sterile technique. A Doppler ultrasound of the portal vein is obtained to determine patency and direction of flow. If the situation permits, a visceral arteriogram is obtained to display the anatomy of the portal venous system.

The right jugular vein is entered with the percutaneous Seldinger technique, and a small catheter is used to obtain pressure readings (systolic/diastolic, mean, mm Hg) in the right atrium and to select a major hepatic vein suitable in size and location. A 55 cm thick walled 16g Calopinto needle (Cook) contained by an 8.5 F catheter and 9 F sheath is positioned in the hepatic vein near its confluence with the suprahepatic inferior vena cava. The terminal few cm of the needle are exposed and passed anteriorly through the hepatic vein wall, across a short segment of liver parenchyma, into an intrahepatic portion of the portal venous system, usually at or near the bifurcation of the vein. Entry into the portal system is determined by aspiration of blood as the needle is slowly withdrawn and by injecting contrast to fluoroscopically identify the portal vein. A guide wire is passed into the splenic or superior mesenteric vein, and the needle is removed. A small catheter is then positioned via the wire into the portal system, and pressure readings and an initial portal venogram are obtained. The tract through the liver parenchyma is dilated to 8 mm diameter with a balloon catheter, and a flexible metal mesh stent (Wallstent, Schneider) is placed in the tract

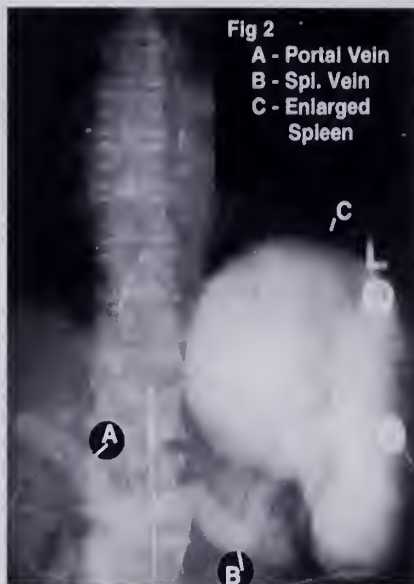
Portal venous hypertension is manifested clinically by bleeding esophagogastric varices, ascites, and hypersplenism. Usually the pathogenesis is resistance to portal blood flow through cirrhotic liver parenchyma. Conservative management with endoscopic sclerotherapy, pharmaceuticals, and diet regulation may become inadequate in controlling these problems at some point in the course of the disease. Traditionally, surgical shunt creation — portacaval, mesocaval, splenorenal — has been a next consideration. Especially in the emergent setting of hemorrhaging varices, the mortality rates of the surgical procedures are high.<sup>1,2</sup> Coagulopathy, acute hepatitis, ascites, and poor nutrition are some of the factors working against a successful outcome in such a situation. Encephalopathy due to induced hepatic ischemia following surgical creation of large shunts can be significant in degree and rate of occurrence.<sup>3</sup> Liver transplantation is a consideration for many of these patients. Previous portal-systemic shunt surgery can result in added difficulty to transplantation.<sup>4,5</sup> The TIPSS procedure addresses these surgical drawbacks advantageously. It is performed under local anesthesia with a low mortality rate in the emergent setting.<sup>6</sup> The shunt created is entirely intrahepatic and does not interfere with later transplantation surgery. The TIPSS shunt functions as a small side-to-side communication between the portal and systemic circulations, and its diameter can be limited to retain some increased portal venous pressure and hepatopetal flow, resulting in little



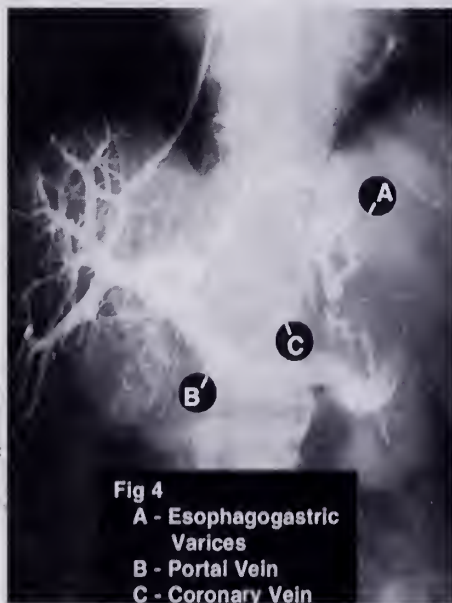
## TIPSS



**Fig 1** — A—Ulcer containing clot.  
B—Gastric varix.



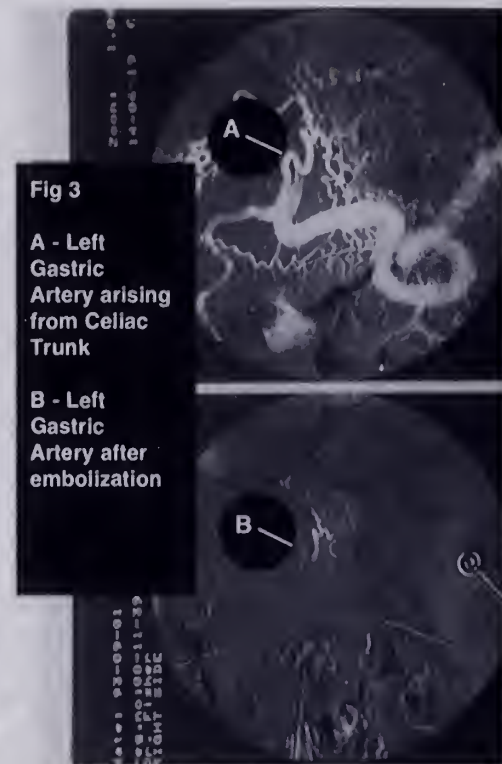
**Fig 2** — Venous phase of celiac arteriogram.



**Fig 4** — Initial portal venogram showing hepatofugal flow into gastric varices.



**Fig 5** — Rapid shunting of portal flow through stent-shunt and decompression of varices.



**Fig 3**  
A - Left Gastric Artery arising from Celiac Trunk  
B - Left Gastric Artery after embolization



**Fig 6** — Follow-up endoscopy showing healing of ulcer and decompression of varices.

and also dilated to 8 mm. Pressure readings and a portal venogram are again obtained. If variceal flow is still present, the stented tract is further dilated to 10 mm. If need be, a second tract can be created parallel to the first. If there is copious hemorrhage through the varices, the coronary vein feeding the varices is easily occluded with stainless steel coils. The catheters and sheath are

removed, and the examination is thus completed.

Baseline endoscopic and Doppler ultrasonic studies are obtained and are used to follow the patient every 3 months.

#### Case 1

The patient is a 79-year-old female who presented to the emergency room with a 12-hour history of



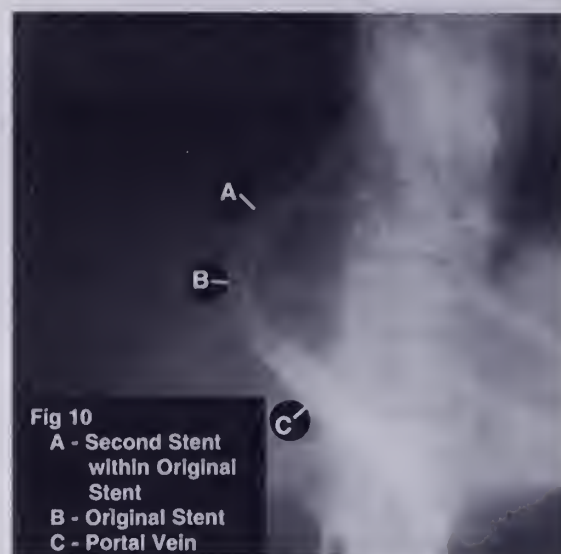


## TIPSS

edematous liver and marked splenomegaly. On the second day of admission, the platelet count fell to 15,000 mm.<sup>3</sup> The patient was moved to the angiogram suite for evaluation of his indwelling intrahepatic stent-shunt. Using the percutaneous transjugular route, a small catheter was maneuvered through the shunt into the portal vein, where pressures were measured at 40/36, m 38, mm Hg. Pressures in the right atrium were 10/5, m 8, mm Hg. The portal-systemic gradient thus was 30 mm Hg. A portal venogram demonstrated flow into large esophagogastric varices and hepatofugal flow in the inferior mesenteric vein (Fig 9). No flow was seen into the liver — it was later learned no hepatopetal flow existed at the time of the original shunt placement. The shunt was totally occluded. A second stent was placed inside the original one and dilated to 8 mm. Repeat portal venogram (Fig 10) demonstrated rapid flow through the recanalized shunt, with no hepatofugal flow into the varices or the inferior mesenteric vein. Pressures were measured at 24/20, m 22, mm Hg; the gradient thus was lowered to 14 mm Hg. The platelet count rose promptly, and the patient improved without incident and was discharged. Ultrasound Doppler 3 months later demonstrated flow in a patent shunt (Fig 11). A CT scan at the same time showed decrease in spleen size, no ascites, and a normal appearing liver (Fig 12).

### Discussion

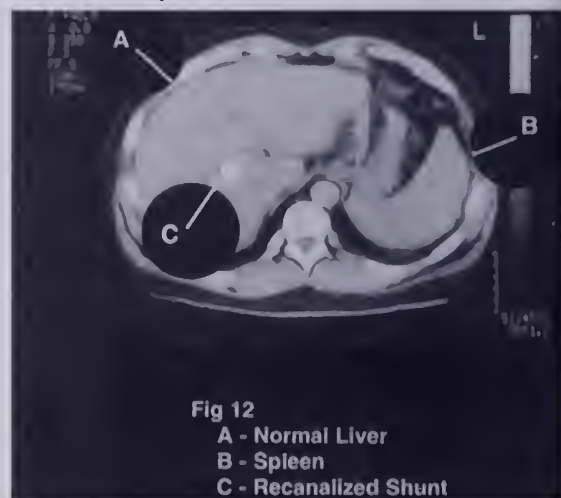
The percutaneous transjugular approach as a method of liver biopsy and cholangiography dates back many years. In 1969, Josef Rosch used this technique to create hepatic vein — portal vein shunts in animals.<sup>7</sup> The patency of the shunts was short lived as no means existed to prevent the tracts from closing due to the natural elastic recoil of the bulky liver tissue. In 1982, Calopinto created shunts on human subjects using repeated and prolonged balloon dilatations.<sup>8</sup> Again, spontaneous closure of the tracts occurred in a majority of cases after short periods of patency. Palmaz was able to obtain long term patency of shunts in animals using his balloon-expandable vascular metal stent in 1983.<sup>9, 10</sup> This led to the first successful clinical TIPSS trial in humans, reported in 1989.<sup>11</sup> Over a thousand successful TIPSS have been performed since then in various centers.<sup>6</sup> The Palmaz vascular stent is short and rigid, and requires multiple overlapping stents to line the parenchyma tracts. Longer, flexible stents (Wall-



**Fig 10** — Portal venogram after recanalization showing rapid flow through stent-shunt and decompression of varices.



**Fig 11** — Color-flow Doppler ultrasound showing flow in recanalization patent shunt (A).



**Fig 12**  
A - Normal Liver  
B - Spleen  
C - Recanalized Shunt

**Fig 12** — CT scan 3 months after recanalization of stent-shunt.

stent) are faster and easier to place, and are used most commonly at present.

Complications of the procedure include inadvertent puncture of the intrahepatic biliary tree, liver capsule, gallbladder, transverse colon, and extrahepatic portion of the portal vein, resulting in hemobilia, peritonitis, and hemorrhage. Sepsis can occur related to failure to maintain sterile technique in the neck area in these sedated patients during the 1 to 5 hours required to complete the procedure. The complication rate is surprisingly low, and many of the complications reported occurred early, as the techniques were first developed.

Primary patency rates of the TIPSS are roughly 80%. The stented parenchymal tracts are gradually lined with a pseudointima which may proliferate to cause significant stenosis or occlusion. The original shunt is easily accessible for redilatation and relining with a second stent. It is possible to create a second TIPSS utilizing a different hepatic vein.

The incidence of resultant encephalopathy after TIPSS is low, and the degree of encephalopathy is typically mild, transitory, and easily treated.<sup>14,15</sup>

The TIPS shunt may be categorized for comparison purposes as a small caliber, side-to-side, nonselective partial shunt. The 8 to 10 mm tract partially decompresses both the splanchnic bed and the hepatic sinusoids as the portal flow pathway to the liver remains intact. The gastrosplenic circulation is not diverted from the portal system, as with the distal renosplenic shunt. Functionally, TIPSS is similar to the small caliber interposition synthetic H-graft, as described by Sarfeh.<sup>16</sup> The low incidence and mild degree of encephalopathy with both of these shunts is probably attributable to retaining some hepatopetal flow or at least some splanchnic venous hypertension, which is thought to limit absorption of toxic substances such as ammonia.<sup>17</sup> Both the TIPS shunt and the H-graft are readily accessible for recanalization with radiological interventional procedures should stenosis or occlusion occur. The lowered pressures in both the splanchnic venous bed and the hepatic sinusoids account for clearing or lessening of ascites, common to all side-to-side shunts. However, large bore side-to-side shunts frequently result in severe encephalopathy as all hepatopetal flow and portal hypertension is alleviated.

The distal renosplenic shunt selectively decompresses the gastrosplenic circulation, thus

lowering pressure and flow in esophagogastric varices. Splanchnic and sinusoidal hypertension is maintained, and hepatopetal portal flow is preserved if new collateral pathways do not develop sufficiently to divert flow away from the liver. Thus, along with preventing variceal bleeding, severe encephalopathy is usually avoided. Portal flow may stagnate as a result of the interruption of the collateral variceal pathway, leading to portal venous thrombosis after distal renosplenic shunt creation.<sup>18</sup> Intractable ascites is a contraindication to this surgery, as the splanchnic bed and hepatic sinusoids are not decompressed.<sup>19</sup> Unlike TIPSS, the morbidity and mortality rates of all the surgical shunts in the emergent, hemorrhaging, unprepared patient are significant.

Twenty-five percent to 40% of patients with esophagogastric varices eventually bleed.<sup>20</sup> Endoscopic treatment with sclerotherapy or banding is safe, avoids initiation or worsening of encephalopathy, and is usually successful at stopping the acute episode. However, rebleeding is common, and each bleeding episode is associated with significant mortality.<sup>21</sup> Multiple sessions of sclerotherapy may convert the variceal bleeding situation to that of congestive gastropathy, which is not amendable to endoscopic therapy. A decompressive shunt or liver transplantation are then considerations. TIPSS seems to serve as a good bridge to maintain patients waiting for transplant-preventing hemorrhage, relieving ascites, and avoiding surgical manipulation in the upper abdominal region.<sup>22</sup>

As with other side-to-side shunts, TIPSS should be useful in treating intractable ascites associated with portal hypertension. Medical treatment of ascites in cirrhosis is based on dietary sodium restriction, diuretics, and bed rest. To avoid complications such as hepatic encephalopathy, renal failure, and dilutional hyponatremia, the ascite fluid is mobilized slowly, often requiring prolonged hospitalization. Tense ascites is best treated by large volume paracentesis, followed by diuretics to avoid reaccumulation. Large volume paracentesis affords a lower complication rate and shorter hospitalization compared to diuretic therapy alone. Peritoneovenous shunts (LaVeen, Denver) are effective in treating ascites in cirrhosis when significant amounts of ascitic fluid recur repeatedly despite adequate medical therapy. However, these shunts have a high rate of obstruction and are complicated by bacterial infections.<sup>23</sup> TIPSS as a therapy for intractable ascites may be reasonable.<sup>24</sup> Again, it may



serve as a temporizing measure in patients with severe ascites awaiting liver transplantation.

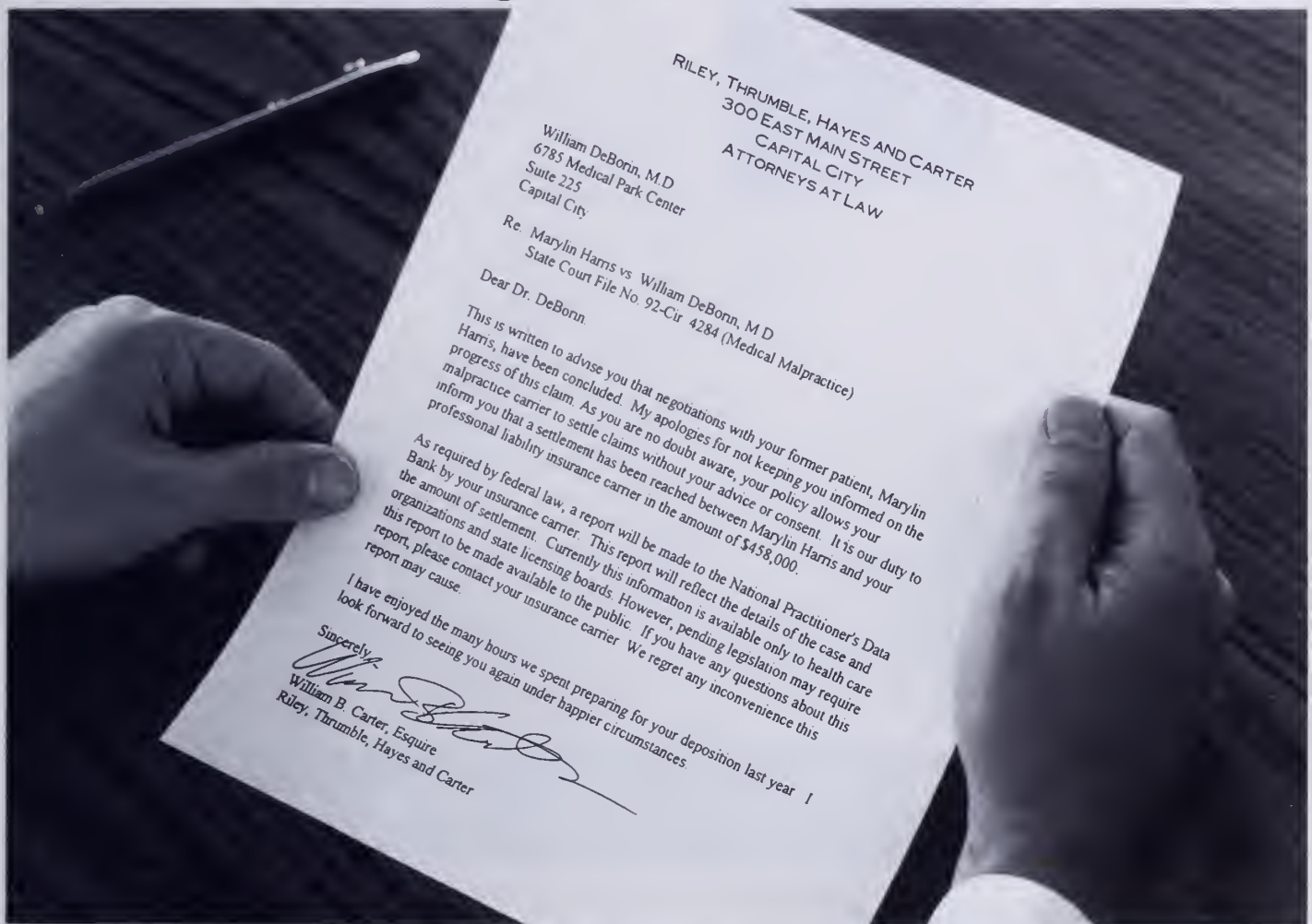
### Summary

With the introduction of metallic vascular stents in the 1980s, the transjugular intrahepatic method of creating a decompressive shunt between the portal and systemic venous circulations has been applied with little morbidity and mortality and good long-term patency. Originally used to treat bleeding varices, its applicability is widening. Evolution and refinement of vascular stents and the TIPSS technique is expected to continue.

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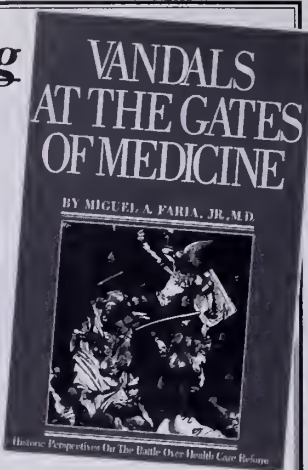
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Dr Faria sweeps centuries of conflict and fratricide in the medical and scientific worlds into a basket of seven chapters. From the primitive practices in Egypt and Mesopotamia to the mercurial scholars of the Renaissance, this chronology tells the tales of our ancestors. That history repeats itself and that our problems mimic others undercurrents the message being delivered. Students of history and the evolution of civilization might be bored slightly from the detail scattered throughout, but exercising our recall from past lessons in the classroom about these epoch times is both educating and clarifying. In fact, some information seemed newly mined, either from the prodigious research of Dr Faria, or from juxtaposing bits of history with the medical metamorphosis.

Many illustrations, numerous pertinent references and a complete index make this book referential as well as timely.

There is a specific point made frequently through the stories, that vandals wear many coats. Before, knights in armor, horsemen with sabers, men of religion with different purposes, rulers with imperial aims, each tried to wrest control from the care givers and fuel their ambitions with the payments from those in

need. Dr Faria recalls the interference and indifference of governments that led to devastating plagues, lifespans shortened by controllable disease and preventable injury. Unholy marriages of the state with medicine produced infamous ethnic cleansings in the past, and now again. Collusion between the lawmakers and the legal actors formed the basis of litigious attacks on the profession. The same holds true today, the author warns, and the vandals have different vestments. Medical entrepreneurs, as politicians, CEOs, bureaucrats, and their offspring, again bang at the doors, where inside we try to care for the sick. To control how we do our medicine is to supply fuel for their attempted hegemony over this critical segment of modern civilization. Just like our predecessors, we physicians have the struggle between our medicine and the attempt to alter for other purposes. Free choice, insatiable scientific curiosity, market forces, and legitimate government care for the needy would perpetuate our excellent medical system.

## *A Scientific Watergate — Dyslexia How and Why Countless Millions Are Deprived of Breakthrough Medical Treatment*

Harold N. Levinson, MD  
Stonebridge Publishing, Ltd  
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This riveting title and controversial subject make reading this book a selective action. Those confronted with patients and friends experiencing problems in reading should at least

consider the author's work.

This book explains Dr Levinson's work for years, experience in diagnosis and previous treatments, and extols his view of dyslexia. Early in the book he seems preoccupied with detailing scientific inertia and with uncovering his opposition. His numerous patient stories, illustrations, tables, and other material convert this early theme into a thoughtful, yet proselytizing work. To sanctify his theory, he uses a "3D-Optical Scanner" to codify data and compare those afflicted with dyslexia with the unaffected. After relating dyslexia to inner ear system dysfunction, he utilizes anti-motion sickness and antihistamine medications in treatment. His results are breathtaking, but as yet not empirically tested or subject to peer review adjudication.

Taking this book on is provocative, if not convincing, but certainly worth the experience.

## *One Man's Medicine*

Charles Harris, MD

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This book builds its message in a series of warm, penetrating, and thoughtful vignettes. Patients problems, considered in context of their overall life, punctuated Dr Harris's 30 years in medicine. That he tells his stories in such detail demonstrates his familiarity with the written word and his facility at creating. Throughout this novel-like work, Dr Harris uses fiction to disguise what happened in his relationships, what medical and psychological tools he used, and what success and failure meant to him and



his patients. Nowhere to be found are care giver, provider, managed care, or other inanimate terms.

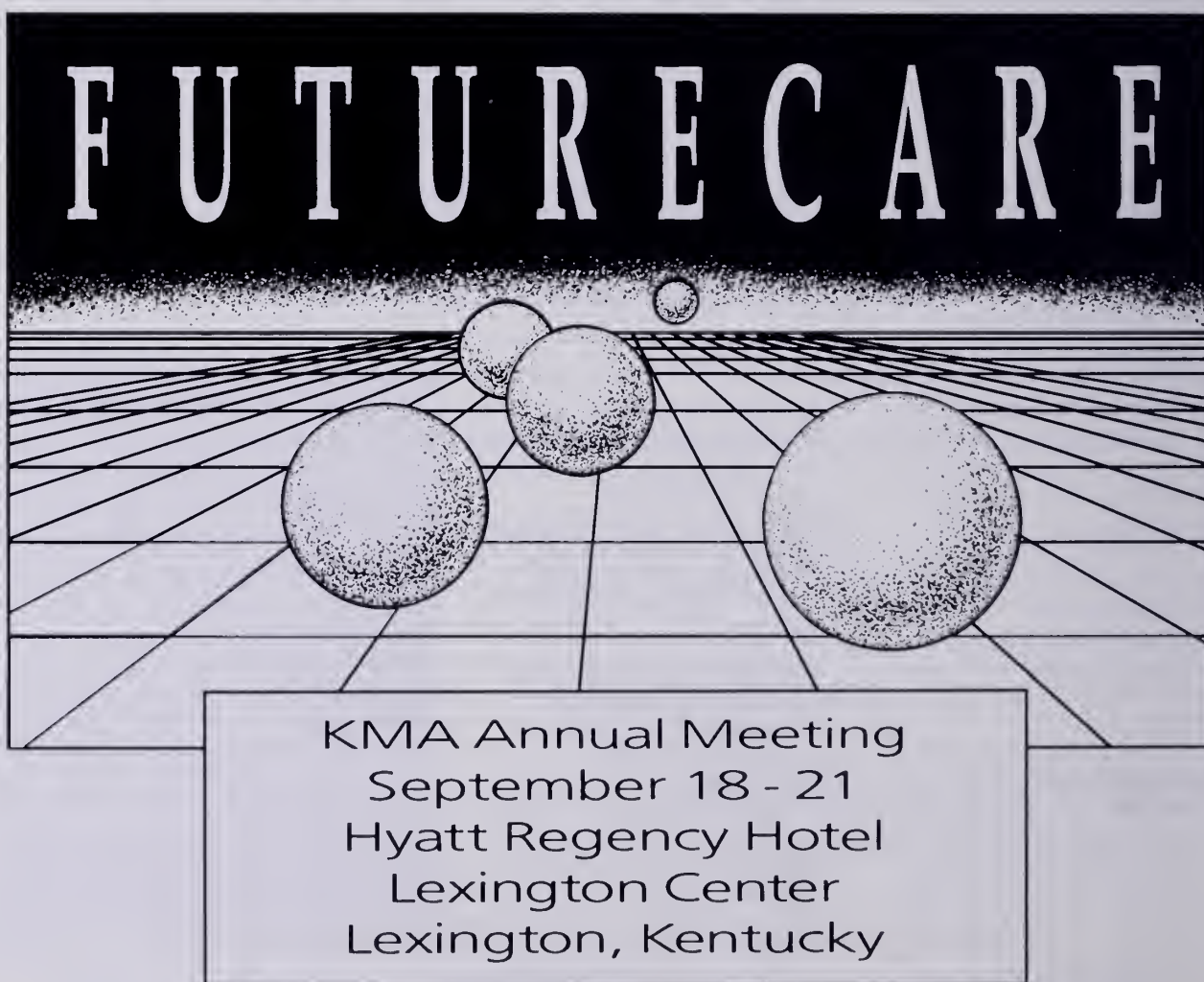
Covered in the familiar white smock, pockets filled with instruments and papers, he and his phantom physician plied their trade. Each story, numbered sequentially, brings the reader to most of medicine's doors.

Entering these lives, the reader recognizes an experience, named differently and located elsewhere. Nevertheless, the feeling of comradeship with Dr Harris seems to bind the physician reader to the book and thus to the author.

Reading *One Man's Medicine* went easily and enjoyably. Today's

medical conundrum aside, this piece of fiction qualifies as simple, poignant, and important for our consumption.

**Stephen Z. Smith, MD**  
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The tension, anxiety, and uncertainty that permeates the health care industry has reached almost intolerable levels. Not only physicians but everyone from the janitors on up are affected.

Five years ago, I wrote an editorial about the patient/physician relationship. Three years ago, I wrote about mammograms. Last year, I wrote about the effects of TV violence on our children. This year, I can't write about medicine. My anxiety level is too high.

I've tried to count my blessings. "My health is good," I thought. But somewhere from the deep recesses of my brain came the thought, "It can't last long under this stress. I'm a set-up for an ulcer, heart disease, or a nervous breakdown."

"I've still got a job," I thought.

But then I remembered I'm Chairman of a hospital-based department at the University, and the contract is going to be renegotiated *again* by the same Governor who has raised taxes, lowered reimbursements, abolished fellowships, and reduced residency positions. I shuddered.

"This, too, shall pass," I tried to console myself; but all I could think was, "Unfortunately, yes, it will probably get worse."

"Life is not easy for physicians," I thought. "That's right," I said aloud, "it never has been. But physicians are the brightest, most resourceful people I know. Think of all the problems we've solved over the years — TB, polio, appendicitis, pneumonia. And we'll solve the current ones, as well. Conflict is a stimulus for change. We can't give up. We must accept the challenge to make tomorrow's medicine less expensive, more accessible, and more effective than today's."

Prozac, anyone?

Jannice O. Aaron, MD

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*"Think of all the problems we've solved over the years — TB, polio, appendicitis, pneumonia. And we'll solve the current ones, as well. Conflict is a stimulus for change."*

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## Hyperlipidemic Treatment Changes on The Medicaid Formulary

To the Editor: As the result of the Drug Formulary Advisory Board (DFAB) meeting of August 19, 1994, recommendations have been made to the commissioner that the lipid lowering classes of drugs including the HMG-CoA Inhibitors, the bile acid sequestrants, niacin and Probucol (Lorelco) be added to the formulary. This basically opens up the entire class of cholesterol lowering agents, but this is not without trepidation. The thought processes that the DFAB went through are felt to be very important as far as choice of a cholesterol lowering agent. This paper is written to educate providers as to possibly the most logical and cost effective way of dealing with hyperlipidemia.

In agreeing to place these agents on the formulary, the Commissioner has requested the University of Kentucky to provide a two-phase educational effort. The first educational phase would involve a series of informative programs for physicians and pharmacists. These programs would be designed to promote appropriate therapeutic strategies for hypercholesterolemia. The second phase would be directed at the sales representatives of the pharmaceutical companies with therapeutic agents available for use in hypercholesterolemia, which have been added to the Kentucky Medicaid Program Outpatient Drug List. This latter program would be designed to reinforce appropriate treatment strategies. Following a period of 6 months, the utilization of these drugs will be evaluated together with the budgetary impact of the *open* coverage status for these agents.

The National Cholesterol Educational Program (NCEP) guidelines were published in 1993.

Upon reviewing the guidelines it becomes obvious that diet and exercise are the mainstays of therapy.<sup>1</sup> The DFAB dealt with drug therapy and tried to discern which was the most cost effective treatment. If one viewed the cost of PCTA at an average of \$15,000 or an average of \$35,000 for CABG, one can see that the use of lipid lowering agents, if they are preventative of coronary artery disease, is a cost savings in the long run. However, we can be even more cost effective if we selectively choose the agents that we use.

In Type IV familial hyperlipidemia Gemfibrozil (Lopid) is one of the mainstays of treatment.<sup>2</sup> However, the role of isolated hypertriglyceridemia in and of itself as a risk factor for coronary heart disease (CHD) is highly controversial.<sup>3</sup>

The intensity of treatment depends on the risk of CHD and other positive risk factors.<sup>4</sup> Patients with known CHD should have a lower targeted LDL level. In the absence of CHD, treatment depends on LDL levels and additional risk factors. These risk factors are summarized in Table 1.<sup>5</sup>

For primary prevention, the NCEP guidelines suggest that all adults 20 years of age and older have serum

Table 1. Risk Factors

Age (Male > 45 years, Female > 55 years, or Premature Menopause Without Estrogen Replacement)
Family History of Premature CHD
Cigarette Smoking
Hypertension > 140/90 or taking anti-hypertensive medication
Diabetes Mellitus
HDL < 35

cholesterol and HDL cholesterol measured every 5 years. Lipoprotein analysis should be performed on males over 45 years of age and females over 55 years of age who:

1. have HDL levels of < 35 mg/dl: or
2. have total cholesterol levels of > 240 mg/dl: or
3. have 2 risk factors and total cholesterol levels of 200-239 mg/dl.

The guidelines suggest that intensive dietary therapy, exercise, and counselling be tried for at least 6 months before initiating drug therapy.<sup>6</sup> In patients with LDL elevations of greater than 220 mg/dl, short periods can be considered. Guidelines for the initiation of dietary therapy based on LDL levels are listed in Table 2.<sup>7</sup>

Drug therapy can be considered for adult patients who continue to

Table 2: Dietary Treatment Based on LDL Cholesterol Level

	Initiation Level	Goal
	LDL (mg/dl)	LDL (mg/dl)
- CHD and < 2 Risk Factors	≥ 160	< 160
- CHD and ≥ 2 Risk Factors	≥ 130	< 130
+ CHD	> 100	≤ 100

Table 3: Drug Treatment Based on LDL Cholesterol Level

	Initiation Level	Goal
	LDL (mg/dl)	LDL (mg/dl)
- CHD and < 2 Risk Factors	≥ 190	< 160
- CHD and ≥ 2 Risk Factors	≥ 160	< 130
+ CHD	> 130	≤ 100



Table 4.

	Cost/Rx	Cost/Recipient
<b>HMG CoA Reductase Inhibitors</b>		
Fluvastatin (Lescal)	\$33.65	\$36.14
Pravastatin (Pravachol)	\$56.99	\$211.35
Simvastatin (Zacor)	\$73.01	\$264.05
Lavastatin (Mevacor)	\$73.54	\$295.90
<b>Bile Acid Binding Resins</b>		
Cholestyramine (Questran)	\$52.50	\$182.75
Colestipol (Colestid)	\$75.04	\$141.98
<b>Other</b>		
Nicotinic Acid (Niacin)	\$10.36	\$53.12
Clafibrate (Atramid-S)	\$19.81	\$83.21
Gemfibrozil (Lipid)	\$52.00	\$194.48
Probucal (Lorelca)	\$66.42	\$235.29
Dextrothyroxine (Chalaxin)	\$77.92	\$311.68

have elevated LDL levels, despite a trial of dietary therapy. Guidelines for the initiation of dietary therapy based on LDL levels are listed in Table 3.<sup>8</sup>

The goal of therapy, whether dietary or pharmacologic, is to achieve an LDL of less than 160 mg/dl in patients with less than 2 risk factors, or to achieve an LDL of less than 130 mg/dl in patients with 2 or more risk factors. In the presence of known CHD, the goal of therapy is to achieve an LDL of less than 100 mg/dl.

The Medicaid cost per prescription and per recipient for cholesterol lowering drugs during a recent 6 month period is shown in Table 4.<sup>8</sup>

The data on prescription cost provides a relative comparison of the expense for a monthly supply for each medication (averaged for all dosage forms). Cholestyramine (Questran) is \$2.40 a day (cost to Medicaid) while 10 grams of Colestipol (Colestid Granules) is \$2.32 a day. These could be appropriate in the lower risk primary patients. These agents also offer less costly lab follow-up and less toxicity as advantages.<sup>10</sup> Niacin at \$0.60 a day for 1000 mg is a reasonable choice especially in a patient with a high cholesterol and low HDL or in a combined

cholesterol/triglyceride elevation. The side effects of flushing, gastrointestinal upset, liver toxicity, hyperglycemia, and hyperuricemia must be taken into consideration.<sup>11</sup>

In patients with severe forms of hypercholesterolemia and for maximum lowering of LDL to the goal of <100, the HMG CoA Reductase Inhibitors are the drugs of choice. As per the DFAB discussion the cost per percentage of cholesterol lowering is definitely in favor of Fluvastatin (Lescal).<sup>12</sup>

The other HMG CoA Reductase Inhibitors lower the cholesterol at a somewhat higher percentage than Fluvastatin (Lescal).<sup>13</sup> However, the cost difference is significant enough that the DFAB believed Fluvastatin (Lescal) should be the first choice HMG CoA Reductase Inhibitor. However, given the ability of the other HMG CoA reductase inhibitors to lower the cholesterol to a greater degree than fluvastatin, the DFAB recommended that other agents in this category also be on the formulary.

More people are being added to the Medicaid roles while the amount of money available remains finite. The goal of the DFAB is to make medications available to the Medicaid recipient without bankrupting the

system. The goal of this paper is to educate the provider as to what appears to be a logical approach that is cost effective and consistent with NCEP guidelines. If only Fluvastatin (Lescal) were used it is estimated that \$1.3 million could be saved over a 1 year time period.<sup>14</sup> But by placing this class of drugs on the formulary we give the provider the option of going to the more expensive medications that are perceived to be more efficacious. We hope to do away with the prior authorization as 97% of these drugs are being preauthorized under the present system.<sup>15</sup> We theorize that there will not be a sudden rise in the cost of this class of drugs as, even under prior authorization, Kentucky's usage of lipid lowering drugs is in the median for other states where these drugs are on open formulary.<sup>18</sup>

Through education, we hope to maintain or even improve cost expenditures until we can see the long-term benefits of fewer PTCAs, CABGs, and prolonged hospitalization. And most importantly, we hope to see improvement in the quality of the lives of our patients, the people of the Commonwealth of Kentucky.

Richard S. Miles, MD  
Robert Kuhn, Pharm D  
Karen Blumenschein, Pharm D  
Clifford E. Hynnyman, MS

## References

1. National Cholesterol Education Program (NCEP), The Second Report of the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol In Adults (Adult Treatment Panel II). National Institutes of Health Publication No. 93-3095. September 1993. Scot M. Grundy, MD, PhD, — Chairman of the Panel. p I; 21-22.
2. J Willis Hurst, *Medicine for the Practicing Physician. Second Edition.* Hyperlipidemia, Jones and Gatto. Butterworth Publ. Stoneham, MA. 1988. p 928.
3. NCEP. 1993. p I; 8.
4. Ibid. p O; 7-8.
5. Ibid. p I; 11.
6. Ibid. p O; 7.
7. Ibid. Adapted from Table on p II; 3.
8. Ibid. Adapted from Table on p III; 3.

9. Data presented to DFAB from Drug Utilization Evaluation XIV. First Health Company. Kentucky Medicaid Utilization, December 1, 1993-May 31, 1994. Presented to DFAB in meeting of August 19, 1994.
10. NCEP, 1993. p III; 4.
11. Tufts University Diet & Nutrition Letter. Volume 12, Number 6, August 1994.
12. Transcript of Drug Formulary Advisory Board Meeting, August 19, 1994. Cabinet for Human Resources, Frankfort, KY. pp 41-45.
13. Ibid. pp 41-84.
14. Ibid. p 45.
15. Ibid. p 20.
16. Ibid. p 112-114.

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## Physicians' Media Image and Medicaid

**T**o The Editor: The recent spate of articles suggesting scandal at the Pineville Hospital and among doctors participating in the Medicaid program are interesting and informative. The state has an obligation to root out abuse and fraud of any type. In doing so the state deserves the enthusiastic support of every citizen and every physician.

On the other hand, I believe that it is important for the citizen who reviews these reports and these activities on the behalf of state agencies understand that the recent publicity surrounding these investigations, some of which have been going on for years, may have an ulterior motive: To tarnish the image of all rural doctors, to a lesser extent

the image of all doctors, and to provide public support for socialization. It is interesting in reviewing the charges discussed in these articles that some of the allegations go back to 1984. Is it just a coincidence that the state has chosen to bring this to the attention of the media at a time when it is attempting to socialize medical care in Kentucky?

As things stand now in rural Kentucky, 10% of the doctors are taking care of 30% or more of the patients in the state. In a sense these doctors are pioneers: For the first time in history they are providing first rate specialized medical services in areas that heretofore have never had these services available.

Is it at all surprising that these doctors who are attempting such an extraordinary endeavor might run afoul of some of the legal and procedural restrictions? Might it be that some of them would become victims of their own ambition? But then again, how else would the people of rural Kentucky obtain their services if not from these types of ambitious and individualistic people?

Historically, centralized state-run medical systems have failed because they are inefficient and too expensive. It is far more likely that the medical care of the future will look more like what is being done currently in rural Kentucky than it will look like what House Bill 250 envisions.

F. Andrew Morfesis, MD  
Daniel Boone Clinic  
Harlan, KY





IF THE NOISE COMING

FROM NEXT DOOR

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It's not a private family matter. Every nine seconds another woman is beaten by her husband or boyfriend. And unless we all work together, it's never going to stop. For information about how you can help stop domestic violence, call 1-800-777-1960.

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Prevention Fund

# National Doctors' Day— National Medical Alliance Month

In 1991, President Bush signed a proclamation proclaiming March 30th as National Doctors' Day. He encouraged all Americans to observe this day with appropriate programs and activities honoring physicians for their contributions to the American public, recognizing their leadership in the prevention and treatment of illness and injury, their work in research, and the countless hours of hard work, stress, and sacrifice in caring for the Nation's citizens. President Bush also recognized the countless others who quietly carry on the work of healing in our communities. More than the application of science and technology, medicine is a special calling, and those who have chosen this vocation in order to serve their fellowman understand the tremendous responsibility it entails. To quote Dr Elmer Hess, a former President of the American Medical Association, "There is no greater reward of our profession than the knowledge that God has entrusted us with the physical care of His people. The Almighty has reserved for Himself the power to create life, but He has assigned to a few of us the responsibility of keeping in good repair the bodies in which this life is sustained."

This year, Barbara Tippins, President of the American Medical Association Alliance, has proclaimed the month of March as National Medical Alliance Month. We will celebrate the involvement of the Alliance as we honor Doctors by our joint participation in community health projects. The Alliance members

participate in many community projects that promote health education, prevention awareness, and antiviolence programs. Alliance members and physicians are involved with schools, churches, and community agencies, working to improve the quality of life in the communities where they live. Medical families respond to the needs of their communities and work as a silent team. In most communities today the problem of violence is one of the greatest concerns.

We hear daily from the media about young people being involved in violent acts. The numbers appearing in our courts on charges of assault, murder, and other forms of violence are increasing at an alarming rate. The number of children under the age of 18 involved in some form of violence, even to the point of serious or fatal injury, has increased dramatically over the last 10 years. As parents, citizens, and members of the medical community we must treat this epidemic just as we have treated other life threatening diseases. It will require the commitment of all citizens to put a stop to the violence that threatens the lives of our youth.

This year in honor of Doctors' Day and Medical Alliance Month, the KMA Alliance is encouraging physician spouses and their families to participate statewide in some community project that denounces violence. I hope you will choose to join in this statewide effort. Together we can make an impact on the future of the lives of people in our state.

A presentation of all projects that physician spouses have been involved



with this year will be at the KMA Alliance Annual Meeting in April. This year the meeting will be held in Somerset, Kentucky, on April 10, 11, 12. Please make plans now to attend. More detailed information will be in the KMA Alliance "BLUEGRASS NEWS." If you are a physician spouse but do not belong to the KMAA and would like to attend our Annual Meeting, please contact KMA Headquarters for more information — Jean Wayne, 502/426-6200.

*Joyce Clark*

**KMA Alliance President**

**Please turn the page for  
important information on the  
1995 KMA Alliance Annual  
Convention**



## Convention Schedule of Events

### SUNDAY, APRIL 9, 1995

- 6-10 PM Hospitality suite open (complimentary light supper)  
8-9 PM Informal reception for county president-elects and state president-elect

### MONDAY, APRIL 10, 1995

- 7:30 AM-12 NOON Hospitality Suite open (complimentary breakfast)  
9 AM-2 PM Registration  
9-10:00 AM Membership/Planning  
9-10:00 AM Bylaws committee  
10:00-11:00 AM Finance committee  
11:00-12 NOON Executive committee  
12:15-1:30 PM Luncheon (Holiday Inn) — Greetings from SMAA and AMAA (special award and program)  
1:45-2:30 PM Pre-convention  
2:30-5:30 PM LAKE AND FUN  
6:30 PM Informal dinner (cookout) — Eagles Nest Country Club  
Applachian entertainment — Compton family

### TUESDAY, APRIL 11, 1995

- 7-9:00 AM Hospitality suite open (complimentary breakfast)  
7:30-9:00 AM Delegate registration (back hall — Holiday Inn)  
9-12:00 NOON House of Delegates  
12:30-2:30 PM Luncheon  
Honoring Past Presidents (Holiday Inn)  
Recognizing Members-at-Large  
Speaker — Humorous, Bob Park  
2:30-3:00 PM BASKET AUCTION  
3:30-4:30 PM Transition meeting  
(shopping for members not involved with transitional meeting)  
6:00 PM Reception — Honoring Marla Vieillard and 1995-96 Board  
Home of Dr Teresa Bentley (Jim)  
7:30 PM Dinner — Eagles Nest Country Club  
Dr Robert Goodin, KMA President, presentation of AMA-ERF checks, awards  
Installation of new officers — Sharon Scott

### WEDNESDAY, APRIL 12, 1995

- 9:00 AM POST CONVENTION BOARD MEETING

\*\*\*\*transportation will be provided to and from all events\*\*\*\*

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# Two New Officers Elected to KMA Board of Trustees

*During the 1994 KMA annual House of Delegates meeting held in Louisville, two new officers were elected to serve on the Board of Trustees. KMA congratulates the following members on their election and thanks them for their valuable leadership.*

**Donald R. Neel, MD**, a pediatrician in Owensboro, was elected to serve a 3-year term as Second District Trustee.

Active in KMA since 1971, Dr Neel chairs the Medical Insurance and Prepayment Plans Committee and is a member of the Physician Organization Study Committee, Child and School Health Committee, and an ex-officio member of the Technical Advisory Committee on Physician Services (Title XIX). He served as a KMA Delegate for Daviess County from 1985 to 1987. Active in leadership roles in the past, Dr Neel is a past president of the Daviess County Medical Society, Owensboro-Daviess County Chamber of Commerce, and Downtown Owensboro, Inc. Professional associations include the Kentucky Pediatric Society,

Owensboro Medical Network, Inc, and the Flying Physicians Association. One of Dr Neel's major interests is flying — private pilot, instrument rating.

Dr Neel attended school in his native Kentucky, earning a BS from the University of Kentucky in 1960, followed by an MD in 1964. His subsequent education included an internship and pediatric residency at Fitzsimons General Hospital in Denver, Colorado, in 1964-67. He is a Diplomate of the American Board of Pediatrics.

A past Chief of Staff and current Chief of Pediatrics at Owensboro-Daviess County Hospital, he also has privileges at Mercy Hospital.

Dr Neel, 56, and his wife, Faye, reside in Owensboro. They have two children and 3 grandchildren.



*Donald R. Neel, MD*

**Kenneth R. Hauswald, MD**, an Ashland surgeon, was elected to serve a 3-year term as 13th District Trustee.

Dr Hauswald has been an active member of KMA since 1978 and has served continuously since 1986 as a KMA Delegate for Boyd County. A past president of the Boyd County Medical Society, Dr Hauswald is extensively involved in other professional and civic organizations including Vice-Chair of the King's Daughters' Medical Center Board of Directors; Assistant Clinical Professor, College of Allied Health Professions, University of Kentucky; Chair, McDowell Cancer Network; Team Physician, Ashland Paul Blazer High School; and membership in American College of Surgeons, Southeastern Surgical Congress, Kentucky Surgical

Society, and American College of Sports Medicine.

A native of New Jersey, Dr Hauswald, 49, is a 1967 graduate of Wake Forest University, Winston-Salem, North Carolina. He earned his MD from Bowman Gray School of Medicine, Winston-Salem, and completed his internship and residency in General Surgery at the University of Kentucky Medical Center in 1971-75. He is a Diplomate of the National Board of Medical Examiners and a Fellow in the American College of Surgeons.

Currently Chief of Surgery at King's Daughters' Medical Center, he also has privileges at Our Lady of Bellefonte Hospital in Ashland.

Dr Hauswald resides in Ashland and is affiliated with Surgical Associates of Ashland, PSC.



*Kenneth R. Hauswald, MD*



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## PEOPLE

**Leah Dickstein, MD**, a professor in the department of psychiatry and behavioral sciences, was named the University of Louisville's 1994 Trustees Award winner.

Dr Dickstein was recognized for participating in and developing "courses which reach out to young people," developing several awards, providing mental health counseling to more than 800 medical students and 100 residents, and promoting healthy lifestyles for students through innovative programs. She was also recognized for promoting opportunities for women and minorities through lectures and workshops.

According to the U of L report, the Trustees said that Dr Dickstein, who entered medical school as a married, 32-year-old teacher with one child, serves as a role model for today's nontraditional students. Students relate to her "been there/done that" perspective.

**Walter L. Sobczyk, MD**, a pediatrician, was recently elected to fellowship in the American College of Cardiology.

The Kentucky Medical Licensure Board has acknowledged longstanding service to the profession by two retiring Board members: **Frank M. Gaines, Jr, MD**, a Louisville psychiatrist, and **John S. Llewellyn, MD**, a Louisville internist. Dr Gaines has served the Board for 17 years and Dr Llewellyn has served 11 years. **Virginia T. Keeney, MD**, a Louisville psychiatrist, is one of four new members appointed to the Board.

**George C. Rodgers, Jr, MD, PhD**, medical director of the Kentucky Regional Poison Center of Kosair Children's Hospital, Louisville, has been elected president-elect of The American Association of Poison Control Centers.

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## UPDATES

### Downsizing Lungs Helps Emphysema Patients

According to a report from the University of Louisville, a new surgical procedure can spare many emphysema sufferers the ordeal of a lung transplant, while giving them near-normal breathing capacity.

The procedure, called lung-reduction or "lung-shaving" surgery, was recently performed by thoracic and cardiovascular surgeon **Daniel L. Miller, MD**, assistant professor of surgery and co-director of U of L's lung transplant program. Dr Miller removes or shaves away damaged lung tissue. Shaving 20% to 30% of the lung can result in an average increase of 60% to 80% in breathing capacity, says Dr Miller.

Lung-reduction surgery may be appropriate for some emphysema patients who aren't young enough or sick enough to qualify for a transplant, but who nevertheless are severely disabled. Most can't walk more than 50 feet, take a shower, or comb their hair. "The surgery gives them an 85% to 90% chance of getting back to normal activity," said Dr Miller, "and a 90% to 95% chance of getting off oxygen."

The surgery's long-term role is still a matter of investigation. It might be an appropriate transplant

substitute in some cases. In others, it could be a way to keep transplant candidates alive until a lung donor can be found.

### KMA Public Education Committee

The KMA Public Education Committee is in the process of developing legislative materials which you may use in our effort to repeal the onerous provisions of HB 250, such as the provider tax and the restoration of Medicaid reimbursement to pre-October 15 levels. In a few weeks you will receive a number of bumper stickers entitled "Repeal the Tax." Be sure to use them — order more from KMA. In addition, the Public Education Committee is working with its PR consultant to develop an informational packet which will be mailed to every member. In that packet will be a letter to legislators who voted *for* the provider tax; a letter to legislators who voted *against* the provider tax, and a letter of opposition to the tax for patients to mail to legislators. The Committee hopes each physician will use the letters as guides to write their legislators, as well as to encourage their patients to write their legislators.

The 1996 Kentucky General Assembly will be the focus of this campaign. "*MediScope*," the publication of the Public Education Committee, will be headlining more issues regarding the punitive practice environment in Kentucky and its effect on access to health care. "*MediScope*" is being received very favorably by patients and it is important that every physician order a number of extra copies to either use in office waiting rooms

or mail with billings. An audio news tape on AMA's Patient Protection Act is being completed and will be available to all radio and TV news outlets and other press media in the near future.

The Committee is also working with the KMA Alliance, led by President **Joyce Clark** of Somerset, and committee member **Jan Crase**. President Clark is developing public education projects and the committee will be providing a grant to the Alliance to carry out their programs. In addition to these activities, the KEMPAC Board has appointed a special committee, headed by a member of the KEMPAC Board and former President of KMA, **William B. Monnig, MD**, to develop programs and seminars which will teach physicians how to run for elective office or to assist candidates. In addition, seminars will be conducted to teach physicians, spouses, and others how to work in campaigns and how they can be most effective in electing officials who share our philosophy. The gubernatorial campaign is a major issue at this time. We are asking every physician to get involved in the political process.

#### Legal Trust Fund Activity

The Kentucky Medical Association House of Delegates established the KMA Legal Trust Fund over 20 years ago. The Legal Trust Fund was established to assist physicians, county medical societies, or other medical groups on legal issues which have the potential to affect the entire body of medicine. The Trust Fund is directed and controlled by the KMA Board of Trustees. Contributions to

the Trust Fund are optional. In the past, approximately 70% of KMA members participated.

As most physicians know, the KMA has been heavily involved in the legal arena for the past 2 years in cases involving the provider tax. The provider tax appeal went to the Kentucky Supreme Court and ultimately to the US Supreme Court. Recently KMA filed a lawsuit to contest the Medicaid reimbursement cuts. That lawsuit has now moved from the Federal District Court, where KMA prevailed, to the 6th Circuit Court in Cincinnati. The legal cost for these two suits is substantial. In December the KMA Board of Trustees reviewed the Legal Trust Fund and is concerned that today's legal climate has resulted in the rapid depletion of our Trust Fund. The Board of Trustees urges every KMA member who has not paid their Legal Trust Fund, to reconsider. The Trust Fund optional assessment is currently \$25.00.

There is a possibility that the Board will have to request quarterly contributions, or possibly other increased assessments in the near future. It is important that we keep an adequate level of funds available for the ongoing lawsuits and any future lawsuits which may come about relating to House Bill 250, particularly the Discount Option Program. Your assistance and attention to this matter are greatly appreciated.

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#### NEW MEMBERS

*Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.*

#### Boyd

**Harry J. Bell, MD** —PMR  
3601 Azalea Dr, Ashland 41101  
1979, Temple U

### Attention Physicians

Rumors floating around the state may vary widely on the number of physicians that have formally terminated their participation in Kentucky's Medicaid program. In an effort to get the most factual information, KMA is interested in hearing from those physicians who have formally withdrawn from Medicaid as a result of:

- recent legislative activities in Frankfort;
- recent Medicaid reimbursement cuts;
- the Medicaid "hassle" factor; or
- any other reason

If you fall in the above category, please forward a copy of any Medicaid termination correspondence to the KMA, 301 N Hurstbourne Pkwy, Louisville, KY 40222-8512.



**Arthur A. Gaing, MD** —GE  
1200 Central Ave #3, Ashland 41101  
1980, U of Rangoon

## Clay

**Edward F. Slothour, MD** —FP  
HC 69 Box 700, Beverly 40913  
1959, Temple U

## Daviess

**Gregory W. McWhorter, MD** —AN  
1412 Frederica St, Owensboro 42301  
1986, U of Louisville

**C. Mark Millsap, MD** —OPH  
2845 Farrell Crescent, Owensboro  
42303

1988, U of Oklahoma

**Charles W. Riccio, MD** —GE  
1614 Forrest Ln, Owensboro 42301  
1986, U of Mondena

## Franklin

**Robert G. Kinker, MD** —OPH  
1001 Leawood Ave, Frankfort 40601  
1977, U of Kentucky

## Henderson

**Marquita H. Ball, MD** —PD  
7253 Rucker Rd, Henderson 42420  
1990, U of Louisville

## Hopkins

**Riad Adoumie, MD** —S  
200 Clinic Dr, Madisonville 42431  
1988, SUNY at Stony Brook

**William R. Schmidt II, MD** —C  
825 Barret Ave, Louisville 40204  
1987, Ohio State U

**Brian D. Stoll, MD** —R  
One Audubon Pl Dr, Louisville 40217  
1987, U of Kentucky

## Letcher

**Abdul R. Kawamleh, MD** —IM  
405 Letcher St, Whitesburg 41858  
1987, Aleppo U

**Suhail Rahhal, MD** —IM  
PO Box 964, Whiteburg 41858  
1988, Damascus U

## Laurel

**Elke Narcisse, MD** —AN  
2336 River Rd, London 40741  
1988, Robert Johnson Med Sch

## Madison

**Mansur A. Khan, MD** —GE  
2209 Mercer Dr, Richmond 40475  
1980, Allama Iqbal Med Col

## Marshall

**Terri H. Telle, MD** —FP  
PO Box 525, Benton 42025  
1989, U of Kentucky

## Northern Kentucky

**David J. Eisenstein, MD** —PTH  
St. Elizabeth Med Ctr, Edgewood  
41017

1989, U of Cincinnati

**Bruce R. Holladay, MD** —ORS  
210 Thomas More Pky, Crestview Hills  
41017

1987, Med Col of Ohio

**Richard D. Kruer, Jr, DMD** —DENT  
20 N Grand Ave #2, Fort Thomas  
41075

**Jeffrey A. McMath, MD** —ORS  
311 S Fort Thomas Ave, Fort Thomas  
41075

1989, U of Cincinnati

## Scott

**John M. Bennett, MD** —FP  
1154-A Lexington Rd,  
Georgetown 40324

1986, U of Arkansas

**Patricia H. Buker, MD** —FP  
3409 Chestnut Hill Ln,  
Lexington 40509

1984, Med Col of Ohio

## Taylor

**Cynthia H. Hart, MD** —R  
211 Cambridge Way, Campbellsville  
42718

1990, U of Louisville

## Wayne

**Jeffrey E. Whitlow, MD** —EM  
RR 3, Box 126C, Monticello 42633  
1984, U of Louisville

## Warren

**Joseph B. Conley, MD** —AN  
PO Box 2020, Bowling Green 42102  
1990, U of Kentucky

## Whitley

**Bryan T. Curd, MD** —IM  
310-W Gordon St, Corbin 40701  
1991, U of Louisville

## Woodford

**Robby K. Hutchinson, MD** —FP  
318 Lynwood Dr, Versailles 40383  
1992, U of Kentucky

**Warren J. Bilkey, Jr, MD** —PMR  
3430 Newburg Rd #111,  
Louisville 40218

1975, U of Wisconsin

**Patricia Blumenreich, MD** —P  
2120 Newburg Rd #407,  
Louisville 40205

1980, U of Republic of Uruguay

**Emmett J. Broadus, MD** —IM  
8813 Royal Oak Dr, Louisville 40272  
1985, U of Louisville

**Katherine S. Darger, MD** —AN  
1510 Cherokee Rd C-3, Louisville  
40205

1986, U of Kansas

**Robert T. Fitzgerald, MD** —EM  
One Audubon Pl, Louisville 40217  
1972, UCLA

**Peter G. Gianaris, MD** —NS  
6400 Dutchmans Pky #120, Louisville  
40205

1984, Northwestern U

**Michael H. Heit, MD** —OBG  
4525 Wolf Creek Pky, Louisville 40241  
1988, St. Louis U

**Fadel M. Hochroth, MD** —PD  
1815 Gardiner Ln #WC27, Louisville  
40205

1957, U of Louisville

**Scott D. Kuiper, MD** —ORS  
14404 Champion Woods Pl, Louisville  
40245

1987, U of Louisville

**E. Arlyn Lua-Canby, MD** —PD  
3 Audubon Pl Dr #L10, Louisville  
40217

1979, Cebu Inst of Med

**Michael A. Nicholas, PhD**  
220 Abraham Flexner Way, Louisville  
40202

**Rosemary Ouseph, MD** —NEP  
2614 Titleist Rd, Louisville 40242  
1988, U of Louisville

**Matthew P. Rogers, MD** —IM  
1501 Polo Fields Ct, Louisville 40245  
1991, U of Louisville

**Gerry A. Bernardo, MD** —IM  
200 Clinic Dr, Madisonville 42431  
1991, Hahnemann

**Bindu T. Desai, MD** —N  
28 Park Ave, Madisonville 42431  
1972, Seth G S Med Col

**Igancio L. Gallardo, MD** —C  
200 Clinic Dr, Madisonville 42431  
1982, U of Puerto Rico

**Wayne J. Naimoli, MD** —N  
200 Clinic Dr, Madisonville 42431  
1981, U of Rome

**Ronald J. Ruszkowski, MD** —HEM  
200 Clinic Dr, Madisonville 42431  
1968, Med Col of Wisconsin

**Muhammad S. Tai, MD** —IM  
200 Clinic Dr, Madisonville 42431  
1985, Dow Med Col

#### Hardin

**Scott E. Kooperman, MD** —AN  
1522 Yorkshire Dr, Elizabethtown  
42701  
1987, U of Florida

#### Harlan

**Sharon M. Colton, MD** —FP  
Cloverfork CI POB 39, Evarts 40828  
1991, U of Louisville

#### Jefferson

**Brian T. Beanblossom, MD** —C  
825 Barret Ave, Louisville 40204  
1988, U of Louisville

**Stuart A. Becker, MD** —GE  
3400 Dutchmans Pky #210, Louisville  
40205  
1972, George Washington U

**Adel M. Bichir, MD** —PD  
2819 Wahoo Dr, New Albany, IN  
1979, Alexandria U, Egypt

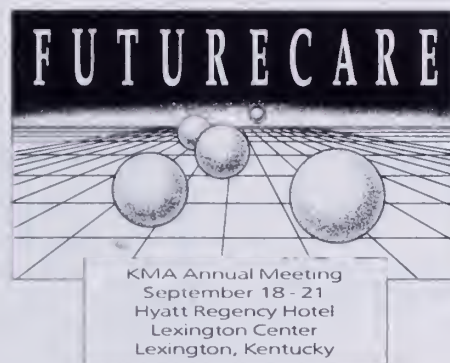
#### In-Training

#### Franklin

**John P. O'Brien, MD** —FP

#### Topkins

**Jerry N. Bean, MD** —FP  
**Ronald A. Berry, MD** —FP



**Kelly L. Cole, DO** —FP  
**David W. Flynn, MD** —FP  
**L. Daniel Hall, DO** —FP  
**Catherine C. Martin, MD** —FP  
**Roy A. Myers, MD** —FP  
**Gaines E. Richardson, MD** —FP  
**Dawn C. Taylor, MD** —FP

#### Jefferson

**Robert L. Berlin, MD** —EM  
**Robert N. Cacchione, MD** —S  
**Sonya R. Collins, MD** —PD  
**Bruce T. Curtis, MD** —R  
**Sharon M. Curtis, MD** —PD  
**Inigo A. Garcia-Zozaya, MD** —PMR  
**Catherine M. Hickey, MD** —P  
**Herbert W. Long, MD** —FP  
**Nicholas A. Midas, MD** —S  
**Edward T. Murphy, MD** —S  
**Christopher K. Peters, MD** —P  
**Kirk D. Prather, MD** —AN  
**Ehsan Qadir, MD** —IM

#### DEATHS

**William O. Preston, MD**  
**Lexington**  
**1911-1994**

William O. Preston, MD, a retired ophthalmologist, died December 10, 1994. Dr Preston was a 1936 graduate of Vanderbilt University School of Medicine and a life member of KMA.

**Samuel S. Gordon, MD**  
**Baltimore, MD**  
**1908-1994**

Samuel S. Gordon, MD, a retired obstetrician-gynecologist, died December 18, 1994. A 1932 graduate of the University of Louisville School of Medicine, Dr Gordon was a life member of KMA.

**Marcus L. Dillon, Jr, MD**  
**Lexington**  
**1924-1994**

Marcus L. Dillon, Jr, MD, a thoracic surgeon, died December 30, 1994. Dr Dillon was a 1948 graduate of Duke University School of Medicine and an active member of KMA.

**Thomas V. Gudex, MD**  
**Columbia, TN**  
**1904-1995**

Thomas V. Gudex, MD, a retired general practitioner, died January 8, 1995. A 1928 graduate of the University of Louisville School of Medicine, Dr Gudex was a life member of KMA.

**Charles R. Gaba, MD**  
**Louisville**  
**1933-1995**

Charles R. Gaba, MD, a dermatologist, died January 14, 1995. Dr Gaba was a 1972 graduate of the University of Louisville School of Medicine and an active member of KMA.

**Hastel L. Townsend, MD**  
**Louisville**  
**1912-1995**

Hastel L. Townsend, MD, a radiologist, died January 23, 1995. A 1937 graduate of the University of Washington School of Medicine, Dr Townsend was a life member of KMA.



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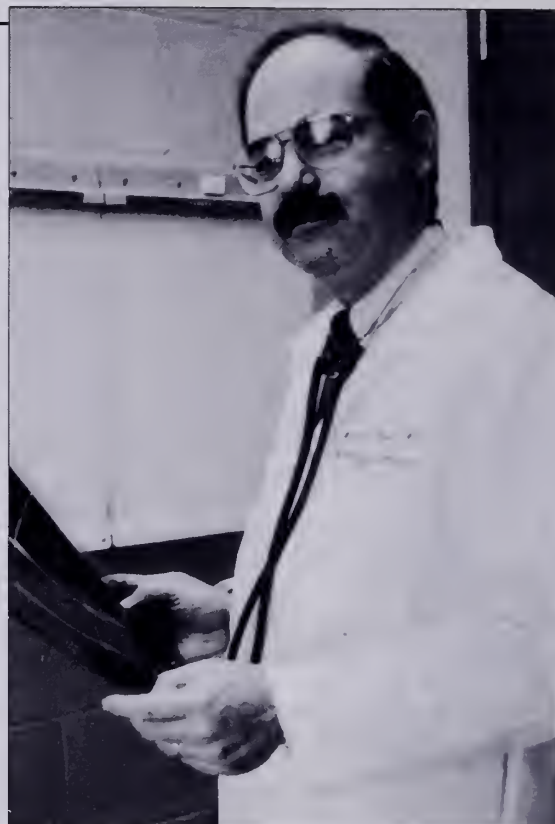
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7-8 — Office Endocrinology, Radisson Plaza Hotel, Lexington, KY. Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

22-23 — Topics in Geriatrics, Radisson Plaza Hotel, Lexington, KY. Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

28-May 5 — 54th Annual American Occupational Health Conference, Sands Expo and Convention Center, Las Vegas, NV. Contact: ACOEM, 55 W Seegers Rd, Arlington Heights, IL 60005; 708/228-6850; FAX 708/228-1856.

MAY

12-13 — Contemporary Pediatrics for the Primary Care Physician, Hyatt Regency Hotel, Lexington, KY. Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

21-26 — 26th Annual Family Medicine & Primary Care Review — Session II, Hyatt Regency Hotel, Lexington, KY. Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of

Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

JUNE

8-10 — Advanced Life Support in Obstetrics, Holiday Inn North, Lexington, KY. Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

JULY

12-16 — Internal Medicine Board Review, Radisson Plaza Hotel, Lexington, KY. Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

OCTOBER

6-17 — Allergy Abroad '95, The Ritz-Carlton Hotel, St. Louis, MO. Sponsored by Washington University School of Medicine. Contact: CME Office, Washington University School of Medicine, Campus Box 8063, 660 South Euclid Ave, St. Louis, MO 63110-1093; 314/362-6893; 800/325-9862.

NOVEMBER

5-10 — 26th Family Medicine and Primary Care Review - Session III, Hyatt Regency Hotel, Lexington, KY. Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

17-18 — Perinatal/Neonatal Symposium, Radisson Plaza Hotel, Lexington, KY. Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.



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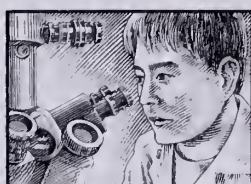
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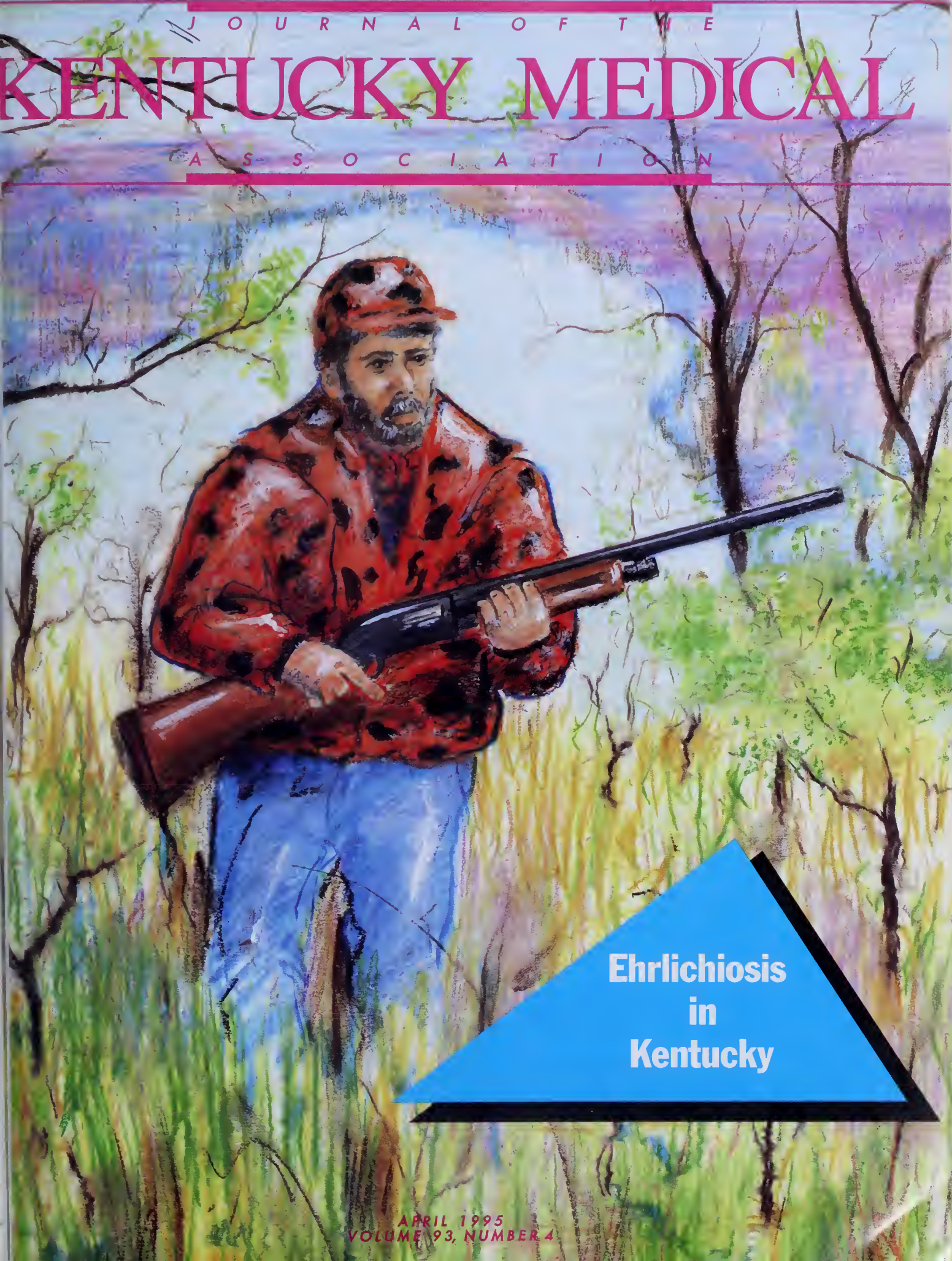


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**Ehrlichiosis  
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JOSEPH SMITH, M.D.

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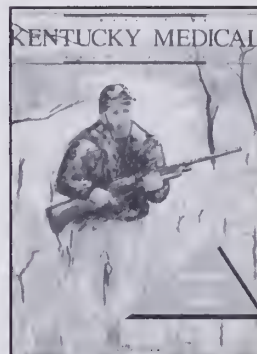
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**COVER:** Ehrlichiosis is a recently described tick-borne disease. The presentation is similar to Rocky Mountain spotted fever and has been reported in southeastern, southcentral, and midatlantic states. See page 132 for a report of three cases of Ehrlichia infection acquired in Pulaski County and Fart Knax, KY. Artwork by Lee Wade of Louisville.

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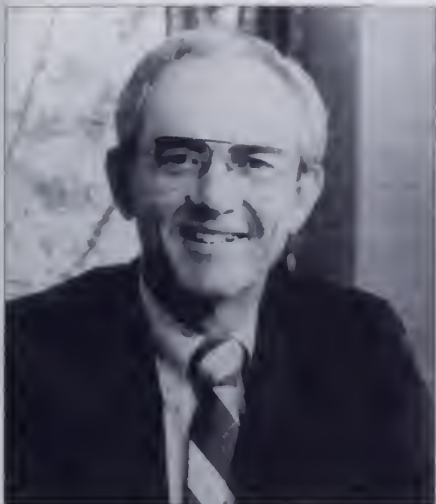
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## The Federation of Medicine — Reengineered

**Y**ou may well be asking "what on earth is *The Federation of Medicine*?" Let me try to explain my concept of the federation and more importantly update you on a very exciting federation study that is underway.

First off, *The Federation of Medicine* includes not only the American Medical Association but also state, county, and specialty medical societies. I share many of the concerns prevalent among physicians today, namely, that our medical organizations are somewhat out of touch and not serving the needs of practicing physicians as fully as they should. In December 1993 the AMA House of Delegates agreed to facilitate a major study of the federation. Please note this study includes not just the AMA, but also state, county, and specialty societies along with medical society executives, special interest medical organizations, and individual physicians, both

---

*"It is clear that physicians feel strongly that The Federation of Medicine must continue to be a federation of physicians as opposed to a federation of health care providers . . . physicians must look out for physicians and not rely on our insurance companies, hospitals, managed care organizations, and legislatures to do it for us."*

---

members and nonmembers of organized medicine. Drs Judy Linger, Wolfe Scofield, and I represent Kentucky in this most interesting endeavor, which includes some 200 physicians and executives from every possible sector of medicine in the country.

The basic purpose of this project is to identify ways in which the whole federation and each of its component parts can better serve physicians and their patients. As marked changes are taking place in the US health care delivery system, it is obvious that we physicians need strong and decisive guidance more than ever before. We all grow weary of paying medical society dues (county, state, AMA, and specialty societies), and yet we all recognize the need for these organizations. This study is about finding better ways to serve physicians, reducing duplication of efforts, and hopefully lowering our annual dues burden.



---

**“The basic purpose of this project is to identify ways in which the whole federation and each of its component parts can better serve physicians and their patients.”**

---

Two of the first questions we have addressed are:

- What will the public and patients expect of the health care system in 10 years?
- What will physicians need from medical societies in 10 years?

After only two of our weekend meetings, the study remains in a discovery phase and certainly has drawn no conclusions. For example, broad areas of expectations of medical societies by physicians include patient advocacy; physician advocacy, especially through improved public image and a collective voice; ready access to medical/scientific and socio-economic information; and very importantly, preservation of medical education standards.

It is clear that many services are being duplicated by various levels of organized medicine, and one of the goals of this study is to improve efficiency, and therefore, effectiveness of function in all the different levels of organized medicine. We hope to define clearly, for each of these levels of organized medicine, what they seem to do best, and through cooperative efforts we should be able to improve effectiveness, and most importantly develop a unified federation of medicine that can better represent all physicians and their patients. It is also clear that physicians feel strongly that *The Federation of Medicine* must continue to be a federation of physicians as opposed to a federation of health care providers. At the risk of sounding paranoid, I believe we are rapidly

learning that physicians must look out for physicians and not rely on our insurance companies, hospitals, managed care organizations, and legislatures to do it for us.

I am pleased to report that the study is a no-holds-barred study. No aspect of the AMA or other organization is off limits to restructuring or even complete replacement. There does seem to be a clear consensus that physicians need an “umbrella organization” of some sort to represent all sectors of medicine. This is increasingly difficult, of course, with the marked diversity among physicians throughout the country. It is hoped this project will better define the role of that umbrella organization as well as the roles of state, county, and specialty societies. Completion of the study is anticipated by January 1, 1996.

Coincident with this study, the American Medical Association has just completed a massive reorganization within its structure by reducing duplication and overlapping of services which should result in significant improvement in its function. This reorganization has taken place under the strong leadership of Executive Vice President Dr James Todd.

Your Kentucky representatives to this study urge you to share with us your views of the needs of physicians and patients in the future so that we may better represent you in this important endeavor.

**Robert R. Goodin, MD**  
KMA President

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# Ehrlichiosis in Kentucky

*Jose H. Salgado, MD; Martin E. Evans, MD; Ardis D. Hoven, MD; Robert C. Noble, MD*



*Ehrlichiosis is a recently described tick-borne disease characterized by headache, fever and chills, leukopenia, thrombocytopenia, and transaminase elevation. The presentation is similar to Rocky Mountain spotted fever but the rash is less frequently present in ehrlichiosis. The diagnosis is confirmed by elevated antibody titers to Ehrlichia chaffeensis or visualization of inclusions in white blood cells and the disease is easily cured with tetracyclines or chloramphenicol. Cases of ehrlichiosis are reported from southeastern, southcentral and midatlantic states. We report three cases of Ehrlichia infection acquired in Pulaski County and Fort Knox, KY during 1992-93.*

**E**hrlichiosis is a tick-borne disease caused by *Ehrlichia*, a genus in the family Rickettsiaceae that parasitizes white blood cells. *Ehrlichia* species were identified as the cause of tropical canine pancytopenia in 1968 and the cause of Potomac horse fever in 1979.<sup>1</sup>

An *Ehrlichia* species, *E. senetsu*, was first identified as a human pathogen in the 1950s in Japan when it was discovered as the cause of Senetsu fever.<sup>1</sup> The first case of human ehrlichiosis in the US was diagnosed in 1986,<sup>2</sup> and since then over 300 cases have been reported. In 1991 *E. chaffeensis* was identified as the primary agent causing ehrlichiosis in the US.<sup>3</sup> We report three cases of *Ehrlichia* infection diagnosed and treated in hospitals in Lexington during 1992-93.

#### Case Reports

**Patient 1:** A 56-year-old healthy white male lawn care worker from near Somerset, Kentucky was hospitalized October 16, 1993, complaining of headache, fever, and chills. Eight days before admission he was scouting for deer and noted ticks on his legs, but did not remember tick bites. Three days before admission, he developed a sudden onset of shaking chills, severe headache, and fever unrelieved by ibuprofen. On physical exam he was alert; his temperature, 100.8°F; blood pressure, 133/84 mm of Hg; pulse, 105 beats per minute; and respiratory rate, 20 per minute. He appeared acutely ill, with mild icterus, but no rash. The remainder of his physical examination was within normal limits. His white blood cell count (WBC) was 6,700/mm<sup>3</sup>, with 27% polymorphonuclear cells, 53% bands, 12% lymphocytes, and 8% monocytes. The hematocrit was 48.5%, and the platelet count was 76,000/mm<sup>3</sup>. The urinalysis

showed trace hematuria, and a chest roentgenogram was normal. The serum lactate dehydrogenase (LDH) was 450 IU/L; the aspartate aminotransferase (AST), 69 IU/L; the alanine aminotransferase (ALT), 78 IU/L; and the total bilirubin, 2.8 mg/dL. A CT scan of the head was normal, and a lumbar puncture revealed a cerebrospinal fluid (CSF) with 2 WBC and 40 red blood cells (RBC) per mm<sup>3</sup>, a normal glucose and protein, and no microorganisms on Gram stain.

The patient received a single 2 gm dose of ceftriaxone intravenously; then he was observed off antibiotics. Forty-eight hours later the fever (maximum 104.6°F) and headache continued, and he developed photophobia and weakness. Repeat lumbar puncture showed a clear CSF containing 51 RBC, 17 WBC per mm<sup>3</sup>; 72% PMN, 28% monocytes; protein, 82 mg/dL, and glucose, 66 mg/dL. Gentamicin and cefazolin were given intravenously without improvement, and 4 days after admission the WBC was 17,000; hematocrit, 51%; platelet count, 36,000/mm<sup>3</sup>; AST, 222 IU/mL; and ALT, 128 IU/L. Multiple blood, urine, and CSF cultures were negative. The reticulocyte count was 0.4%. On the fourth day after admission, a diagnosis of ehrlichiosis or Rocky Mountain spotted fever was considered, and doxycycline 100 mg orally twice daily was started. Within 1 day, the patient became afebrile with marked relief of his headache and weakness. He was discharged 6 days after admission with instructions to continue doxycycline for 2 weeks. Serologies for rickettsia, cytomegalovirus, and toxoplasmosis were negative. *Ehrlichia* serology drawn on the ninth day of illness showed an IgM titer of 1:1024 and an IgG titer of 1:320.

**Patient 2:** A 27-year-old white male member of the National Guard with a past medical history of prostatitis was hospitalized in Mt. Sterling, Kentucky on July 2, 1993, complaining of headache and fever. He had been bitten by ticks while camping at Fort Knox, Kentucky from June 16 to June 20. Eight days before admission, he experienced back pain. Three days before admission, he began to have a headache and fever; prostatitis was diagnosed, and trimethoprim-sulfamethoxazole was prescribed. On the day of admission, he suffered two episodes of nausea and vomiting and one episode of diarrhea. The physical examination on admission revealed a temperature of 104°F and prostatic enlargement. The white blood cell count was 8,700/mm<sup>3</sup>; hematocrit, 44.1%; platelet count, 202,000/mm<sup>3</sup>. The serum LDH was

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427 IU/L; AST, 232 IU/L; ALT, 194 IU/L; and total bilirubin, 1.1 mg/dL. A roentgenogram of the chest showed small bilateral pleural effusions and mild interstitial changes. A urinalysis was unremarkable. He was treated with ciprofloxacin 500 mg orally twice daily for prostatitis, and cefotaxime 1 gm intravenously every 8 hours plus gentamicin 80 mg intravenously every 8 hours for possible sepsis. The symptoms continued and the patient developed a rash, polymyalgias, and polyarthralgias. Four days after admission, he was transferred to the University of Kentucky Medical Center. His temperature was 102.8°F; blood pressure, 128/82 mm of Hg; pulse, 120 per minute; and respiratory rate, 20 per minute. He had a macular rash on the trunk and extremities and posterior cervical lymphadenopathy. Inspiratory crackles were heard in the left lung base, and the abdomen was tender to palpation in the right upper quadrant. His WBC was 10,100 with 27% PMN, 16% bands, 50% lymphocytes, and 5% monocytes. The urinalysis showed trace blood, 5-10 white cells, and 2+ bacteria. The LDH was 475 IU/L; AST, 210 IU/L; and ALT, 241 IU/L. On the day of transfer, gentamicin and cefotaxime were discontinued, and tetracycline 500 mg orally four times daily was started. He became afebrile 36 hours later, and all his symptoms improved. The patient was discharged 7 days after admission to complete 2 weeks of tetracycline and 6 weeks of ciprofloxacin treatment. Serologies for viral hepatitis, toxoplasmosis, leptospirosis, Lyme disease, and Rocky Mountain spotted fever were negative. Cytomegalovirus IgG was reactive and *E. chaffeensis* serology drawn on day 7 of his illness showed an IgG titer of 1:1024, and an IgM titer of 1:320.

**Patient 3:** A 75-year-old white man from Somerset, Kentucky with a history of congestive heart failure and atrial fibrillation was hospitalized in Somerset on June 15, 1992, complaining of a 4-day history of fever, chills, rigors, a slight headache, confusion, transient nausea and vomiting, and progressive malaise and debility. The patient spent a lot of time outdoors and was frequently exposed to ticks. At the time of admission he had a tick attached to his leg. He had a dog and cat at home, and he fished, hunted, and skinned animals. At the Somerset Hospital, he was neutropenic, thrombocytopenic, and had a progressive rise of transaminases, LDH, and CPK. The chest roentgenogram was clear. He was treated with imipenem, but the fever continued. He appeared to

be toxic and for this reason was transferred 2 days after admission to St. Joseph Hospital in Lexington.

The physical exam on the day of transfer revealed a flushed, toxic man with a maculopapular eruption on his chest and back. His eyes were injected and his neck stiff. The rest of his physical exam was unremarkable. The WBC was 4,200/mm<sup>3</sup>, with 55% polymorphonuclear cells, 26% bands, 16% lymphocytes, and 3% monocytes. The hematocrit was 41%; and the platelet count was 43,000/mm<sup>3</sup>. Three days after admission the PTT was prolonged at 47.1 seconds, the fibrinogen was low at 197 mg/dL, and the fibrin degradation products were markedly elevated at a concentration of 320 to 640 mcg/ml. The urinalysis showed proteinuria, bacteriuria, and 5-10 white cells. The chest roentgenogram showed mild cardiomegaly. The CT scan of the brain without contrast was negative. A lumbar puncture showed a CSF containing 9 RBC/mm<sup>3</sup>, and 19 WBC/mm<sup>3</sup>; 26% PMN, 55% lymphocytes, and 15% monocytes. The CSF protein was elevated at 102 mg/dL, and the glucose was 51 mg/dL.

On the day of transfer imipenem was stopped, and treatment with ceftazidime and gentamicin started. Three days after admission gentamicin was stopped, and doxycycline and vancomycin were started. During the hospital stay, the patient developed disseminated intravascular coagulation that was treated with heparin and resolved within a few days. A bone marrow biopsy was nondiagnostic. The patient's mental status improved. He became afebrile and regained his strength. The following tests were negative: ANA, serologies for brucellosis, leptospirosis, tularemia, Rocky Mountain spotted fever, cytomegalovirus IgM, Lyme disease, and hepatitis B and C. The *E. canis* IgG titer was >1:1024, and the IgM titer was <1:20. The patient was discharged in good condition on July 1, 1992.

## Discussion

*E. chaffeensis* is a gram-negative coccobacilli that can infect the cytoplasm of leukocytes and can be seen by light microscopy as inclusions in leukocytes. *E. chaffeensis* is closely related to *E. canis*.<sup>3</sup> The Lone Star tick, *Amblyomma americanum*, is suspected to be the vector of human ehrlichiosis since it is a human parasite with a distribution similar to the reported cases of ehrlichiosis.<sup>4</sup> Ninety percent of patients report tick exposure.<sup>6</sup>

Human ehrlichiosis has been reported from

southeastern, southcentral, and midatlantic states. Surveillance in some areas of North Carolina and Oklahoma estimate an annual incidence of 5.3 cases per 100,000, which is similar to that of Rocky Mountain spotted fever in endemic areas.<sup>4</sup> Most cases of ehrlichiosis occur from April to October, with a peak incidence in July. The disease affects mostly males who live in rural areas and engage in outdoor activities. Our three patients were men; two were infected in June, and the other one was infected in October. Two acquired their disease in Pulaski County, and one was infected during military maneuvers at Fort Knox.

The spectrum of the disease ranges from asymptomatic infection<sup>5</sup> to severe illness and even death. The incubation period ranges from 1 to 21 days.<sup>4</sup> The disease starts suddenly with malaise, fever and rigors, and severe headache. Petechial or macular rash is present in approximately 40% of the cases.<sup>6</sup> Other symptoms include myalgia, anorexia, nausea and vomiting, diarrhea, abdominal pain, and confusion. Physical findings are minimal: pharyngitis, localized lymphadenopathy, and hepatosplenomegaly are found in a small proportion of patients. Most of the patients recover, but some have complications such as acute renal failure, acute respiratory distress syndrome, and meningitis. Deaths have occurred in a patient with persisting infection in spite of treatment<sup>7</sup> and in an infected AIDS patient.<sup>8</sup>

Hematologic abnormalities are common in ehrlichiosis. Transient leukopenia, lymphopenia, and thrombocytopenia have their nadir 5 to 7 days after the onset of symptoms, while anemia occurs sometimes into the second week of illness.<sup>9</sup> Leukocyte inclusion bodies are present in less than 5% of the peripheral blood smears. Elevation of the aminotransferases is found in 90% of the patients during the first week of illness. Bilirubin elevation is present in at least one third of the patients. Other laboratory findings include creatinine elevation and hyponatremia. Disseminated intravascular coagulation and CSF pleocytosis are occasionally found.

Ehrlichiosis should be suspected in a patient with a history of tick exposure who develops an acute febrile illness with leukopenia, thrombocytopenia, and elevated aminotransferases. The diagnosis is confirmed serologically with acute and convalescent phase sera or by identifying inclusions called morula in mononuclear or polymorphonuclear cells in peripheral blood smears or in bone marrow.<sup>10</sup>

The differential diagnosis of ehrlichiosis is extensive, including viral illness (infectious mononucleosis, enterovirus, cytomegalovirus, viral hepatitis), Rocky Mountain spotted fever, meningitis, sepsis, and Kawasaki syndrome. If there is history of tick exposure, then RMSF, tularemia, Lyme disease, babesiosis, and Colorado tick fever should be considered. Think of ehrlichiosis in a patient who appears to have Rocky Mountain spotted fever without the spots. Ehrlichiosis is sometimes referred to as Rocky Mountain spotless fever.

Treatment must be started empirically when ehrlichiosis is suspected. The tetracyclines induce dramatic response in most patients. Doxycycline 100 mg orally twice daily for 10 days is usually prescribed. Chloramphenicol is also effective and can be used when tetracyclines are contraindicated, such as in pregnancy and children less than 8 years of age.<sup>11</sup>

In summary, ehrlichiosis, a recently described tick-borne disease, is present in Kentucky. Patients may present with an unexplained febrile illness with rigors, headache, myalgias, leukopenia, thrombocytopenia, and transaminase elevations. The diagnosis is made on clinical grounds and confirmed by elevated antibody titers to *E. chaffeensis*, and the treatment is tetracyclines or chloramphenicol.

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# Automated External Defibrillators Used by Emergency Medical Technicians: Report of the 1992 Experience in Kentucky

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*Automated external defibrillators (AED) have been authorized for use by Emergency Medical Technicians (EMT) in Kentucky since March 1991. Emergency Medical Services (EMS) which use these devices are required to submit annual reports to the EMS Branch. During 1992, 17 services were approved to use AEDs. The device was used by 12 services on 93 victims of out-of-hospital cardiac arrest. Of the 93 victims, 27 were defibrillated, eight were resuscitated to hospital admission, and three survived to hospital discharge. The overall survival rate was 3/93 (3.2%). For patients receiving defibrillatory shocks, the survival rate was 3/27 (11%). This percentage is comparable with the survival rates reported from other predominately rural states where AEDs have been used by EMTs. Possible protocol violations and inadequate documentation were also identified from these reports. In summary, EMTs in predominately rural Kentucky can use AEDs to achieve survival rates for out-of-hospital cardiac arrest comparable with other rural states.*

The survival rate from out-of-hospital cardiac arrest is essentially zero without medical intervention. During the past 30 years, the deployment of trained personnel — emergency medical technicians (EMTs) and paramedics — functioning in an organized system of emergency care has been able to significantly improve survival of out-of-hospital cardiac arrest.<sup>1</sup> Studies from the 1970s identified four key factors as crucial to a favorable outcome: early access to emergency care, bystander CPR, early defibrillation, and early advanced life support (ALS).<sup>2</sup> These factors have been linked together by the American Heart

Association as the "Chain of Survival."<sup>3</sup> Of these four factors, the most important is early defibrillation.<sup>4,6</sup>

Because early defibrillation makes the biggest impact in increasing survival, the emphasis has been on EMS systems to deliver defibrillatory shocks at the earliest possible time.<sup>3,6,7</sup> Basic EMTs can be taught to recognize important rhythms seen in cardiac arrest and correctly use a manual defibrillator improving the survival rate of out-of-hospital cardiac arrest in urban and suburban regions from about 5% to 20% for patients in ventricular fibrillation.<sup>4,8-11</sup>

The potential benefits of training basic EMTs in the skills of arrhythmia recognition and manual defibrillation was criticized as being too costly for rural areas because of the costs associated with the initial training, the equipment purchase and maintenance, the need for skill updating, and the anticipated low frequency of use.<sup>12</sup> Advances in computer technology have made it possible to manufacture automated external defibrillators (AEDs) with arrhythmia recognition capabilities, circumventing these problems.<sup>13-20</sup>

In 1990, pilot programs in Florence, Bath, and Rowan counties were initiated to train EMTs in the use of AEDs. EMT-AED training and service programs were formalized by Regulation 902 KAR 13:120 effective March 12, 1991. The first EMT-AED service was authorized for Carroll County on June 26, 1991. By December 31, 1992, 17 services covering all or parts of 14 counties were authorized for EMT-AED. The annual reports from these 17 services submitted to the EMS Branch for 1992 were reviewed in order to assess the impact of EMT-AED programs on the treatment of out-of-hospital cardiac arrest in Kentucky.

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## Methods

For the time period January 1, 1992, to December 31, 1992, the 17 ambulance services authorized to use AEDs were required to submit a report to the EMS branch for all instances where the device was used on a victim of cardiac arrest. For each patient, the following information was requested: (1) age; (2) sex; (3) whether the arrest was witnessed or not; (4) whether there was bystander CPR or not; (5) time the call was received by the service; (6) time the EMS vehicle was dispatched; (7) time of arrival of EMS squad at scene; (8) time of first defibrillatory shock; (9) time of arrival to hospital; (10) total time from receipt of call to arrival at hospital; (11) initial rhythm when AED first connected to patient as determined by retrospective review of the rhythm recording by the ambulance service medical director; (12) number of defibrillatory shocks attempted at the scene; (13) presence of pulse on arrival, before first defibrillatory shock, and after each shock; (14) resultant rhythm after CPR and/or defibrillation as determined by the ambulance service medical director; (15) resuscitation to hospital admission; and (16) survival to hospital discharge.

The population of counties and cities was obtained from the 1990 Census, Bureau of Census, Department of Commerce.

Data was analyzed using the SAS(R) statistical program (SAS Institute, Cary, NC). For comparison of continuous variables between groups, the student's t-test was used unless otherwise indicated.<sup>22</sup> If data was not normally distributed, or the numbers in each group was small, the Wilcoxon rank-sum test was used to compare continuous variables.<sup>23</sup> Dichotomous categorical variables were compared with the Mantel-Haenszel chi-square statistic or the Fisher's exact test, then the expected cell counts were below five.<sup>24</sup> Crude odds ratios were calculated by the logit estimator with precision-based confidence intervals estimated according to the method of Woolf.<sup>25</sup> The p-values given are always for two-tailed tests. Linear regression was used to assess the association between continuous variables.<sup>22</sup> A p-value of 0.05 or less was interpreted as being statistically significant.

## Results

For the reporting period, five ambulance services reported no use (zero patients) and the other 12

reported between 1 and 21 patients (Table 1). A total of 95 patients were reported where the AED was applied; 93 were in cardiac arrest and constitute the study population. Two patients were not initially in nor did they develop cardiac arrest.

The mean age of all patients was  $69 \pm 14$  years (range 25-97). Fifty-two were male and 41 female. Sixty-five were witnessed arrests, 32 were unwitnessed, and 2 were unknown. Bystander CPR was performed in 38 cases and not performed in 55. Witnessed arrests were more likely to report bystander CPR: 32/65 versus 4/26 (chi square = 8.898,  $p < 0.01$ ). Ambulance response times from receipt of call to arrival at scene was  $7.9 \pm 5.1$  minutes. Eight patients were resuscitated to hospital admission, and three survived to hospital discharge. Overall survival rate was 3/93 or 3.2% of all victims.

The initial rhythm was reported as ventricular fibrillation (VF) in 17, electromechanical dissociation (EMD) in 6, asystole in 42, unknown in 26, agonal in 1, and idioventricular rhythm (IVR) in 1.

Twenty-seven (29.0%) of the patients received defibrillatory shocks; 15 received one shock, 4 received two shocks, 7 received three shocks, and 1 received four shocks. The initial rhythm for those 27 patients receiving defibrillatory shocks was VF in 16, unknown in 8, and asystole in 3. The specificity of EMT-AED for rhythms where defibrillation is not indicated (asystole, EMD or IVR) was 47/50 or 94%.

For the 17 patients in VF, no shocks were administered in 1 case, one shock was administered in 10 cases, two shocks were administered in 2 cases, and three shocks were administered in 4 cases. The sensitivity of rhythm recognition for VF was 16/17 or 94%.

For patients receiving defibrillatory shocks, pulses were present at the scene after the first shock in five cases, after the second shock in one case, and after the third shock in no cases.

Resultant rhythms after defibrillation and/or CPR were reported were asystole in 40, unknown in 41, agonal in 2, bradycardia in 1, EMD in 6, sinus in 2, and VF in 1.

Statistical analysis of EMS response times found no significant difference for the following categories of patients: received defibrillatory shock, did not receive defibrillatory shock, VF as initial rhythm, non-VF as initial rhythm, resuscitated to hospital admission, not resuscitated to hospital admission, and survival to hospital discharge. The mean time from arrival on the scene

Table 1.

County Population	Ambulance Service	Total Amb Runs 1992	City Population	# Patients	# Patients Defibrillated	# Patients Admitted	# Patients Discharged
Bath 9,692	Both County Amb Serv	1496	Owingsville 1,491	4	1	0	0
Boone 57,589	Flarence EMS	3254	Flarence 18,624	5	2	1	1
Boone 57,589	Union EMS	319	Union 1,001	4	3	2	1
Corroll 9,292	Corroll Co Emerg Amb Serv	1334	Carrolltan 3,715	6	1	1	0
Corroll 9,292	Daw Carning Corp Amb Serv	33	Carrolltan plant only				
Jefferson 664,937	Anchorage EMS	796	Louisville 269,063	3	1	0	0
Jefferson 664,937	Jeffersan Ca EMS; St Matthews FD	14753	Louisville 269,063	2	1	0	0
Kenton 142,031	Erlonger Fire and Rescue Sq	1236	Erlanger 15,979	9	2	1	0
Lowrence 13,998	Lifestor Amb Serv	3196	Louisa 1,990	2	1	1	0
Logon 24,416	Logon Co Amb Serv	2281	Russellville 7,454	17	5	1	0
Morsholl 27,205	Morsholl Co Amb Serv	7651	Benton 3,899				
Mortin 12,526	Martin Co Amb Serv	2069	Inez 511				
McCrocken 62,879	Angel of Mercy Amb Serv	7107	Poducuh 27,256	20	6	1	1
Oldhom 33,263	Ballardsville/Oldhom EMS	246	Crestwood 1,435				
Pendleton 12,036	Pendleton Co Amb	843	Falmouth 2,378				
Pike 72,583	Elkhorn City Amb Serv	704	Elkhorn City 813	7	1	0	0
Rowon 20,353	Morehead Rown Amb Serv	3085	Morehead 8,357	14	3	0	0
TOTAL				93	27	8	3

to the initial defibrillatory shock was  $1.9 \pm 2.2$  minutes (range 0 to 10). Of the eight who were resuscitated to hospital admission, six received defibrillatory shocks as compared to 21/85 of those not admitted (Fisher's exact  $p = 0.0068$ ). All three survivors to hospital discharge received defibrillatory shocks as compared to 24/90 who did not survive (Fisher's exact  $p = 0.023$ ).

There was no correlation with county population and resuscitation to hospital admission ( $P = 0.62$ ) or survival to hospital discharge ( $p = 0.66$ ). AED use correlated with the total number of ambulance runs ( $p = 0.035$ ), but resuscitation to hospital admission ( $p = 0.57$ ) and survival to hospital discharge ( $p = 0.22$ ) did not.

In summary, the strongest association and the largest predictor of both resuscitation to hos-

pital admission and survival to hospital discharge was defibrillation by the AED.

### Discussion

The survival rate of patients in cardiac arrest in this series was only 3.2%. For patients in ventricular fibrillation, the survival was 11%. Data has not been collected on survival of out-of-hospital cardiac arrest in rural Kentucky prior to the institution of the EMT-AED program, so direct evaluation of the impact of this program is not possible. In comparison, the survival rate reported in this series compares favorably to the experience in other predominately rural states.<sup>8-11, 16, 19-21</sup> In Iowa, survival of patients in VF increased to 17% after institution of an EMT-AED program.<sup>16</sup> In rural Min-



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nesota, prior to the institution of an EMT-AED program, survival from VF was 3%, and increased to 17% after institution of the EMT-AED program.<sup>19</sup> In Tennessee, survival of patients with VF after initiation of an EMT-AED program was 9%.<sup>20</sup> Although the survival rate is small, the rate in communities without early defibrillation is even more dismal.

This series found a relatively high percentage of witnessed arrests (66/93 or 71%) and EMS response times of less than 8 minutes (62/93 or 67%). Despite this, there were only a small number of patients in VF. Even for witnessed arrests, only 15/64 (23%) were in VF. Even in the best of circumstances with this population, a minority of patients potentially benefit from early defibrillation. For this minority of patients, however, early defibrillation is their only hope.

We were not able to show an association between bystander CPR and resuscitation to hospital admission or survival to hospital discharge. Other studies have shown an impact of early bystander CPR on survival.<sup>2,3,5,26</sup> In this series, only 48% of patients with a witnessed arrest received bystander CPR.

As opposed to the analysis of Gallehr and Vukov<sup>27</sup> of data from Iowa, Minnesota, and Wisconsin, we were not able to find a correlation between county population nor the size of the ambulance service (as indicated by the number of ambulance runs) and survival of out-of-hospital cardiac arrest. Thus, any service, big or small, can obtain the expertise necessary to use the device and make an impact on survival.

As noted, there were at least two situations where protocol violations may have occurred. The first was in applying the AED in victims with palpable pulses. The AED protocol states that it should only be applied in the unresponsive, non-breathing, and pulseless victim. It is likely that the AED was hastily applied to two victims before the presence of pulses was appreciated. The second potential protocol violation was in the three victims with a reported initial rhythm of asystole who received defibrillatory shocks. The rhythm analyzer of an AED can misinterpret ECG motion artifact as ventricular fibrillation and inappropriately recommend or deliver a defibrillatory shock.<sup>28</sup> Therefore, the AED protocol states that the patient is not to be moved or touched — no CPR, ventilation, or transport — during the 12 to 15 seconds the AED is analyzing the rhythm. It is likely that motion artifact — either from chest compression or ventilation — during the analysis

period was detected and misinterpreted as VF in the three patients with asystole who were defibrillated.

The other observation is the large number of situations where requested information was reported to the EMS branch as unknown; particularly the rhythms. Even though AEDs have voice, event, and ECG recording capabilities, several ambulance services did not report rhythm information. It is not known whether this is the result of equipment malfunction or the lack of review by the medical director. It is recommended that further reports to the EMS branch be submitted with rhythm strips for each victim where the AED was used.

In summary, the survival of out-of-hospital cardiac arrest is bleak without early defibrillation. In our rural population, only a minority of patients will have potentially treatable rhythms (VF) on arrival of an EMS vehicle. For this minority of patients, early defibrillation under the EMT-AED protocol provides some hope, although survival is still not very good. The AED is easy to learn and use and there appears to be little potential for error in usage. However, the AED will not make up for deficiencies in rapid access, bystander CPR, and ALS care. AEDs can play a role in those services and communities where commitment to these principles exist.

## Conclusion

Although only 3.2% of all patients with out-of-hospital cardiac arrest survived, 11% of those in VF survived. This is a positive impact on survival for patients in rural areas. Communities and ambulance services should give serious consideration to implementing AED programs as part of a comprehensive effort to save patients sustaining out-of-hospital cardiac arrest.

Institution of an AED program should be undertaken in addition to continuing efforts to educate the community on recognition of medical emergencies, early access, and bystander CPR, as well as continuing efforts to improve access and ambulance response times for all Kentuckians.

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# Health Promotion Schools of Excellence: A Model Program for Kentucky and the Nation

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*This article reviews the development and progress of an innovative, comprehensive school health project in the Jefferson County school district known as the Health Promotion Schools of Excellence (HPSE). This project features unique working relationships between public and private entities seeking a common goal: "A Healthier Community." The goals and development of HPSE have been formulated to coincide with the emerging directives of the Kentucky Education Reform Act (KERA) as well as the growing pressures to control health care costs through effective preventive measures. The results of testing following the first and second years of the project show an encouraging trend of improved physical fitness levels for all students (grades K-12) and improving levels of health knowledge and attitudes in elementary level children (grades 4-8) as well as school faculty and staff. These initial results, although encouraging, will only be meaningful if they translate over time into a healthier, more responsible cohort of adolescents and young adults when compared to their peers not involved in the project. The project, while only in its third year of development, has already been recognized at regional and national levels as a successful model of a comprehensive school health program. As the project continues and grows, the authors anticipate developing one of the nation's largest and most comprehensive longitudinal data bases of childhood and adolescent health information.*

It has been estimated that approximately 70% of all deaths in the United States are due to chronic diseases such as cardiovascular disease, cancer, bronchitis, and diabetes, while an additional 5% are due to preventable injuries.<sup>1</sup>

The premature development of many of these diseases are known to be associated with modifiable "risk factors" such as cigarette smoking, dietary habits leading to obesity and hypercholesterolemia, and a sedentary life style. While the incidence of cigarette smoking is declining in adults,<sup>2</sup> there is little evidence that other behavioral risk factors are being substantially modified, and recent information has actually shown an increasing level of obesity in the US.<sup>3</sup> It is widely acknowledged that the most beneficial time to influence health related behavior would be during childhood when lifelong habits regarding smoking, dietary preferences, and physical activity levels are being developed. Yet recent data suggest that the health related behaviors of children in the US are declining,<sup>4,5,6,7</sup> and there is little data available regarding successful strategies to alter this trend in either small or large populations of children. In the current environment of health care reform, it is vitally important that cost-effective and proven strategies to develop healthier children be explored in order to gain greater control of exploding health care costs.

## Background

The Health Promotion Schools of Excellence (HPSE) project had its beginning in the summer of 1991 through the Jefferson County Medical Society's Subcommittee on Health Education. Members of the subcommittee representing the Medical Society, the Jefferson County Public Schools, and the Jefferson County Health Department developed the program with several unique features: (1) emphasis not only on student education but also on school faculty, staff, and community development; (2) development of health promo-

1. School health education
2. School health services
3. Healthful school environment
4. School physical education
5. School food services
6. School counseling and psychological services
7. Integrated school and community health promotion efforts
8. School site health promotion for faculty and staff

**Fig 1 — Listing of the Eight Components of Comprehensive School Health**

tions programs which would be unique to each individual school based on their own defined needs and resources; (3) creation of a week-long Summer Health Institute which would provide selected members of participating schools with not only didactic information regarding health education, but also successful teaching strategies and information on community resource utilization; and (4) define and develop age-appropriate testing tools to create a longitudinal database of the health status of project participants. The need to develop the program within this framework was based on both recently expanded concepts of comprehensive school health<sup>8</sup> (Fig 1) and some of the key elements of the recently introduced Kentucky Education Reform ACT (KERA) such as site-based decision making and staff development initiatives. The project directors chose to limit the focus of the program to four basic areas of health and disease prevention. These areas were: **cancer control; cardiovascular risk reduction; injury prevention; and physical fitness.** The project sought to evaluate not only participants' levels of health knowledge and physical fitness but also health related attitudes and, most importantly, health related *behaviors* which would have the most significant impact on long-term benefits.

The project received funding in its initial year (1992-93) from the Southeastern Group Foundation (formerly Blue Cross/Blue Shield of Kentucky Foundation) and the Alliant Health System (through its Community Trust Fund and Office of Child Advocacy). Additional support was provided in the project's second and third year through funding from the Office of the Jefferson County Judge/Executive and a full-time research associate provided by the Jefferson County Public School System. Voluntary support services were continually provided by the staff of the Jefferson

County Public Schools, the Jefferson County Health Department, and dozens of individuals representing both public and private community agencies.

The project is administered through an Executive Steering Committee with a project director and full-time project manager. There are also several working committees including a Research and Evaluation Committee, a Standards and Selection Committee, an Institute and Curriculum Committee, and a Public Relations Committee.

The project had its formal initiation in the spring of 1992 with school selection. The first Summer Health Institute was held in August 1992, and formalized evaluation and testing was begun in the beginning of the 1992-93 school year.

## Methods

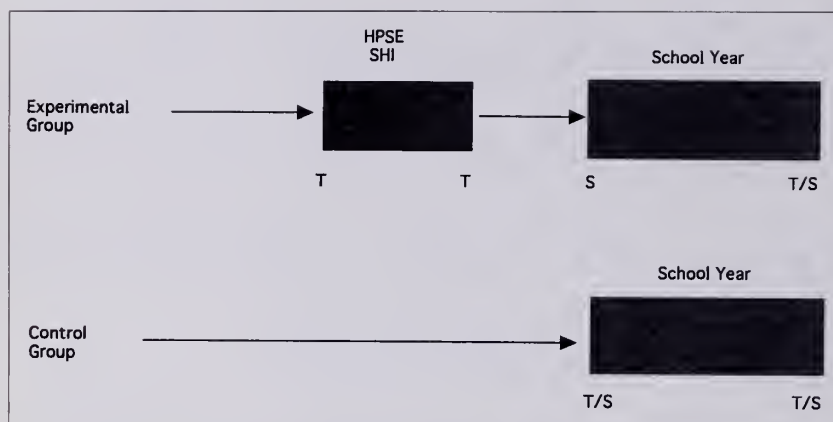
**School Selections.** All schools in the Jefferson County Public School system were eligible (elementary, middle, and high schools). Schools were selected by the Standards and Selection Committee on a competitive basis via written application. Schools were selected based on two primary components: school commitment at the administrative, faculty, and community level; and a well-defined set of school needs, health promotion goals, and action plans. In the second and third year, previously selected schools were required to resubmit a yearly application in order to continue in the project.

**School Participation in the Summer Health Institute.** Selected schools were required to send a three-member team to a five-day Summer Health Institute. The Institute provided participants with didactic information regarding cancer and heart disease, nutrition in relation to disease prevention, injury prevention and physical fitness, as well as theories and teaching strategies to affect change in knowledge, attitude, and behavior regarding health related issues. Opportunities to develop individual school-based action plans utilizing community agencies as well as individual professional resources, including a project coordinated "Adopt-A-Doc" program for each school, were also made readily available.

**Evaluation and Testing Tools.** Because of the wide range of ages involved in the project (kindergarten through adult school staff), multiple age-appropriate testing tools were required to assess physical fitness, cognitive knowledge, health related attitudes, and health related behaviors. Faculty and staff participated in the Emory



## Health Promotion Schools of Excellence



**Fig 2 — Health Promotion Schools of Excellence Study Design**  
 T = teacher testing; S = student testing; SHI = Summer Health Institute

University Health Risk Appraisal Survey and the YMCA's "Y Way to Fitness" evaluation, while students (grades K-12) participated in the American Alliance of Health Physical Education, Recreation and Dance (AAHPERD) "Physical Best" Program which is a curricular and testing tool for physical fitness. In addition to Physical Best, students in grades 4 through 8 completed the Student Health Education Evaluation (SHEE) survey which assesses health knowledge, attitudes, and behaviors, while students in grades 9 through 12 completed the Youth Risk Behavior Survey (YRBS) which assesses health related behavior and level of risk.

**Study Design.** The success of the program is being evaluated via a cohort study design with the participating schools (students and staff) being the group studied (Fig 2). The intervention being evaluated is the effect of the Summer Health Institute and subsequent school-based programs on staff and student test scores. Staff are tested before and after the Institute and at the beginning and end of the school year. Students are tested at the beginning and end of each school year. Initial evaluations will compare composite scores of participants at the beginning and end of the school year. Future analysis will be made by comparing participant scores with those of nonparticipating schools in the district and/or by using the established standards of each testing tool.

**School Support, Requirements and Activities.** Each school received at least a \$1000 per year implementation fund, a "Physical Best" educational kit, age appropriate testing materials

with technical support, a periodic health information newsletter for each student's family, and continual support from the project management to help coordinate community resources and supervise data collection. Each school was required to organize a health promotion committee, complete all scheduled testing, and submit a monthly progress report of health promotion activities. There were no specific requirements for health promotion activities; however, schools were strongly encouraged to develop projects which would combine various school disciplines and involve not only students and teachers, but non-teaching school staff and school families as well. Many unique individual programs have been developed, but common projects have included health fairs, food awareness programs, walking programs, and First Aid/CPR training.

## Results

Fifteen schools were chosen in the project's first year (1992-93) representing 9 elementary, 3 middle, and 3 high schools with a combined total of over 11,500 students. The project has grown in size each year, and for the 1994-95 school year, the project involves 24 schools representing 16 elementary, 4 middle, 3 high schools, and 1 environmental school. These schools represent a total of over 16,000 students. Only 2 of the original schools are no longer involved in the project, which suggests that the benefits of the project outweigh any additional demands in the minds of already heavily burdened school staffs.

Testing results were quite variable on an individual basis, but combined scores of groups of tested individuals show encouraging 1 year trends.

Adult Summer Institute participants in the first year showed slight gains in dieting behavior, motor vehicle safety, frequency of PAP smears, and breast and rectal exams in women, but no gains or losses in weight, exercise, smoking, alcohol consumption, mammograms in women, or rectal exams in men.

Composite results of all students participating in the AAHPERD "Physical Best" physical fitness assessment in the 1993-94 school year showed improvement in all performance categories and a stable measurement of body mass index (Table 1). Results of the SHEE survey in students grades 4-8 during the 1992-93 school year showed improvement in four categories of health related attitudes and six areas of health knowl-

**Table 1.** Health Promotion Schools of Excellence Physical Best Student Gains (K-12)

		Percent Achieving AAHPERD Standard				
N =		Run	Sit-ups	Pull-ups	Flex	BMI
9755	Oct 93	22%	49%	33%	59%	73%
8663	Apr 94	31%	52%	36%	65%	73%
	% Gain	9%	3%	3%	6%	0%

edge (Table 2). No change in health related behavior was seen in either children in grades 4-8 via the SHEE survey or in the adolescents in grades 9-12 via the YRBS survey. There was also no change in the level of risk detected in adolescents in grades 9-12 who took the YRBS survey.

**Cost.** The cost per student varied slightly each year depending on the level of funding and number of schools participating during that school year. During year one (1992-93) the funding level was \$100,000 and the number of students participating was approximately 11,600, which equals approximately \$8.61 per student. If one maintained that cost and assumed a 3% consumer price index increase compounding annually, the entire cost of the program for an individual child from kindergarten through high school (13 years) would be \$135.00. If the program proves to permanently effect health behavior and thus decrease lifelong health risks and expenses, the savings from a \$135.00 investment could be substantial.

## Discussion

There is little doubt that altering certain life style choices, such as smoking, drinking, dietary habits, and physical activity patterns, would have a profound positive impact on the health of Americans and greatly reduce health care costs in this country. What remains to be demonstrated is the most effective way to bring about the necessary changes. Prevention programs in targeted adult populations and at the work site can be effective in the short term, but it is often difficult to maintain the improvement achieved if the programs are not maintained, primarily because most life style choices are ingrained from childhood and are very difficult to alter. It would seem logical therefore that the most effective long-term changes should be possible when they occur in childhood.

**Table 2.** Health Promotion Schools Of Excellence SHEE\* Gains (Grades 4-8)

	Oct 92	Oct 93	Gains
Attitudes			
Personal Responsibility	32%	44%	12%
Healthy Body	29%	37%	8%
Healthy Environment	20%	47%	27%
Rights and Roles	37%	41%	4%
GAINS IN ALL 4 CATEGORIES			
Knowledge			
Human Sexuality	13%	48%	35%
Safety & First Aid	30%	40%	10%
Disease Prevention	31%	39%	8%
Substance Use/Abuse	41%	52%	11%
Consumer Health	42%	66%	24%
Community Health	31%	64%	33%
GAINS IN 6 OF 11 CATEGORIES			

\* SHEE: Student Health Education Evaluation

Schools are a logical place to focus preventative health programs for several reasons. First, as previously mentioned, childhood is the ideal time to develop healthy life style patterns before they become the difficult to change "bad habits" of adulthood. Second, schools are in a uniquely central position in our society because of the number of people involved in them and the number of people they can affect. With nearly one-fifth of the US population (students plus staff) having schools as their "workplace" plus all of the families of students and staff who might be affected, a successful prevention program developed in all schools could have a profound impact on the entire population. The third reason to have prevention programs centered in schools is that they remain a highly trusted institution. A recent survey by the National Civic League showed that in 1994 more people put their trust in the school systems (44%) than in religious institutions (40%) or voluntary organizations (37%), and well ahead of the Federal Government (16%) and political parties (11%). In fact the survey revealed that people put the most trust in other individuals like



## Health Promotion Schools of Excellence

themselves (52%), rather than in other institutions or agencies, to both identify and solve the problems in their lives.

A recent article by Lavin et al highlighted the need to develop comprehensive school based health promotion.<sup>9</sup> This article reviewed 25 selected reports of both government and private studies of the health of America and its youth. The article cites five common themes to these reports. These five themes include the previously mentioned issues of life style related "social morbidities," the cost effectiveness of prevention programs, and the central position of schools in our society. The other two themes were the fact that the health status of children, including issues of safety, nutrition, and psychosocial status, is vital to successful academic achievement, and that there is a need for a more comprehensive and integrated approach to health care education in schools, which would include not only school curricula, but also local community agency involvement.

The lack of a comprehensive and integrated approach is underscored by a recent publication of the US Department of Health and Human Services which reviewed findings of over 60 school health projects underway in the US.<sup>10</sup> Not a single one of these programs integrated more than 5 of the 8 components of comprehensive school health (see Fig 1) and most only focused on 2 or 3. Other limitations of reviewed programs included focusing only on either primary or secondary school children, and no estimates of program costs are given.

The HPSE project is among the most unique and innovative programs of comprehensive school health in the nation for several reasons: (1) It may be the only project in which schools may address all eight components of comprehensive school health; (2) It focuses on students in elementary, middle, and high schools; (3) The project is primarily funded and administered by local community agencies and organizations. (It is the hope of the project directors that funding and control remain in the hands of local entities which could best define the health related needs of their own community); (4) The project allows for autonomous, individual school-based decisions about the types of programs and activities which best suit each school's own needs and resources. (This site-based, decision-making process both allows for maximum creativity in developing successful activities and coincides with the goals of the KERA); and (5) The projects large

size and broad age range of evaluated individuals will allow for the rapid development of one of the largest and most comprehensive data bases in the nation on health related information during childhood and adolescence.

The initial results of the project are encouraging. It was both expected and gratifying to see the broadest range of improvements in elementary school-aged participants. These children should be the most amenable to change and the most likely to sustain changes into adulthood. It is not surprising that the fewest changes were seen in adolescents, since many lifelong behavior patterns have already been developed by the teenage years and will be difficult to change. The true success of this project can only be demonstrated if elementary aged children now in the project demonstrate significant improvement in health related behaviors as adolescents and adults. Some indication of success should become apparent in 3 to 5 years when HPSE elementary students enter HPSE middle and high schools, since the SHEE and YRBS evaluations examine both behaviors and risk levels. It may be decades before the true test of success can be measured, which would be a demonstration of a lower incidence of life style related diseases and healthier, longer lives in persons affected by the program.

### Summary

The HPSE began with the concept that a broad-based school environment which focused on health related information and attitudes across multiple school disciplines, and involved shared responsibility among school students, staff, and families, would result in long-term improvements in health related behaviors and thus a healthy community. Our initial results show that the proper school environment can result in improved levels of fitness, and increased levels of knowledge and attitudes in children. It is our belief that the continued presence of this kind of environment can yield more health conscious adolescents and adults, whose improved life styles could result in substantial gains in the battle to control health care costs in Kentucky and the nation.

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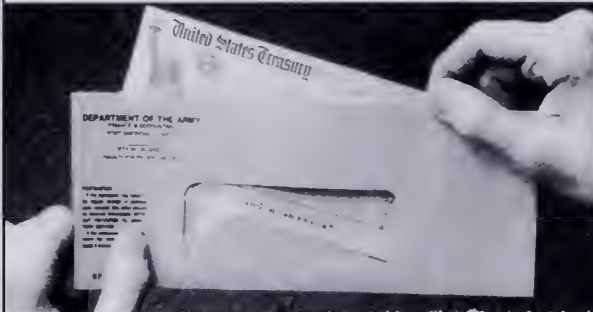
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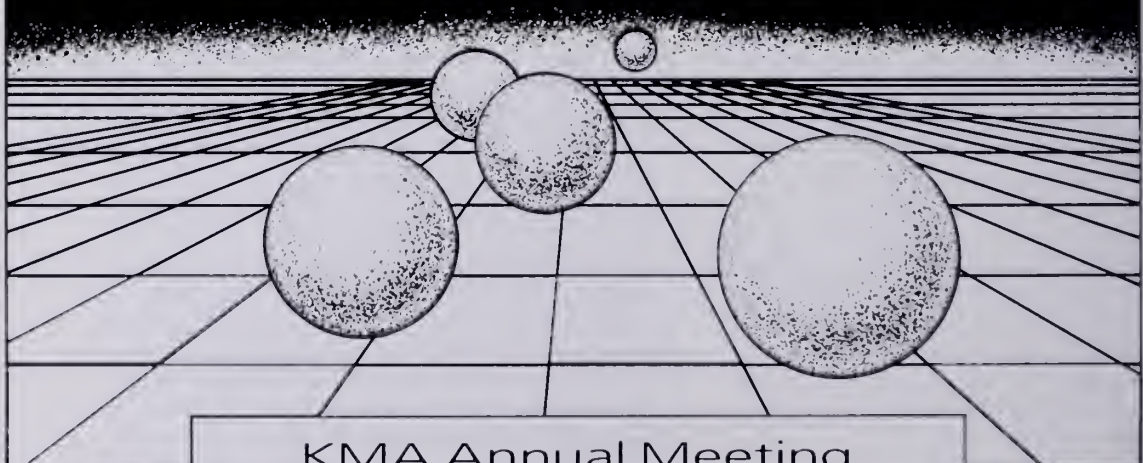
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# Can We Galvanize?

**O.K.** So there will be no national health policy to come out of the 104th Congress. The unwieldy and cumbersome Clinton Health Plan was dead in the water and won't surface again. However, the problem that it was to address — health care to the needy, the poor, and the non-insured — goes on.

So I wonder now if the private sector of medicine can help pick up some of the slack? Can we galvanize into action physicians of all disciplines to once again don the mantle of altruism and donate their time and energy to serve the underserved?

Here are some loose and random thoughts to implement my proposal:

1. Physicians agree to donate 4 to 8 hours per year to serve the indigent.
2. Organize clinics at public buildings, health departments, libraries, mission homes, churches, etc to render this care.
3. Offer this service at the hours of the day for convenience of the patients, so as to not jeopardize the income of the working poor. Ideally between 6:00 PM and 10:00 PM.
4. Ask for volunteers to serve as auxiliary help to run the logistics, paper work, and appointments of these said clinics.
5. Reserve certain days of the month for sub-specialty consultation, ie, neurology, ENT, OB-GYN, orthopedics, and general surgery.

I know the above plan is strewn with holes and pitfalls, some of which will be difficult to avoid. A surgeon

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*“Can we galvanize into action physicians of all disciplines to once again don the mantle of altruism and donate their time and energy to serve the underserved?”*

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friend of mine, for whom I have great regard, said he thought my idea was wonderful, but just what do we do with those patients who are four-plus sick and in need of immediate attention? He mentioned as examples someone with acute appendicitis or a strangulated hernia. Where is that patient sent? Who does the surgery? Who pays for operating room and recovery room fees? Who pays for laboratory testing, intravenous fluids, and antibiotics? Alas, I had no answers.

An internist to whom I went for advise and opinion, told me he felt the idea was sound. He did express concern that the truly indigent patients frequently have not the money to pay for needed medications that the physician may prescribe. Again, no answer.

Help with these knotty problems may come from many sources. County medical societies and their administrative staff can offer support, as can local industries and business groups. Even the patients we serve and treat may offer support and not

ask for remuneration.

Needed financial support may be easy to come by, and could be derived from many sources. Donations from medium and large size companies might be available. Grants from foundations would be another avenue of needed funds. What is paramount, is that no financial aid received goes for salaries, either for professional or lay persons. The service we would render in this proposal must be charitable and altruistic in the finest tradition.

Admittedly, we have had in place the Kentucky Physicians Care Program since 1985, and it has done a magnificent service. A review of their records show that over 2,300 physicians and 1,000 physician assistants have rendered care to a potential 136,142 eligible individuals in the 10 year period. Along with that we have had 3,462 dental referrals to 363 participating dentists. Now add to that 33,452 free prescriptions filled by multiple first line drug companies, and you begin to grasp the magnitude of service rendered.

Why then you ask do we need yet another program to serve the indigent? Well, in my proposal, care will not be rendered in a doctor's office, but in a “neutral” location, staffed totally by volunteers after office hours and in the evenings. Appointments may not be needed, and “walk-ins” will be encouraged.

Well, there it is! A plan ambitious in theory and goals, yet replete with difficulties in its implementation. I welcome both your criticism and your suggestions.

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The children at St. Jude Children's Research Hospital take life one day at a time. At St. Jude, every second counts. The children here are fighting for their lives.

The doctors and researchers at St. Jude are working to find a way to defeat the deadly enemy: childhood cancer. Since St. Jude Hospital opened in 1962, it has forged new treatments for childhood cancer and has helped save the lives of thousands of children around the world. But the battle has just begun.

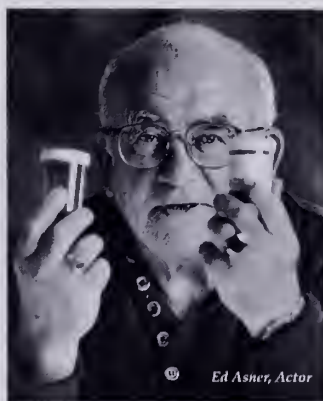
You can join the fight. To find out how, write to St. Jude Children's Research Hospital, P.O. Box 3704, Memphis, TN 38103. Or call 1-800-877-5833.



**ST. JUDE CHILDREN'S  
RESEARCH HOSPITAL**

Dr. Thomas, founder

## Attention: Physicians



Ed Asner, Actor

## Have your patients' medicines had a check-up?

Many of your patients take several different medicines every day. Separately each one works well. But if they take two or more different medicines in combination without checking with you to be sure they work safely together, they can sometimes be harmful...even dangerous.

The next time you prescribe a medicine, ask your patients:

*"What other prescription and nonprescription medicines are you taking?"*

A public service message from the National Council on Patient Information and Education (NCPPIE) and the U.S. Administration on Aging

Write for free information on patient medicine counseling.

**OR FAX:  
(202)638-0773**

Mail to:

◆◆ NCPPIE  
◆◆ 666 Eleventh Street, NW  
Suite 810  
Washington, DC 20001

## Epinephrine for Anaphylaxis

**T**O THE EDITOR: Many deaths occur from anaphylactic reaction to insect sting due to the ignorance of laymen and sometimes even health care workers who don't know what to do. A nurse who was a patient of mine told me about her brother who was cutting a hedge around a physician's home. He was stung and had an anaphylactic reaction. He went inside and called for an ambulance. The physician didn't know what to do, the EMT workers didn't know what to do, and the doctors at the emergency room didn't know what to do. He died.

It is possible for death to occur within five minutes of a sting. In most cases, this is insufficient time to get to a doctor and to a hospital. I became a "lone crusader" to educate laymen (especially teachers) to the dangers of anaphylactic reaction to insect sting. I was able to get the AMA to draft a model bill to allow trained laymen to legally administer epinephrine to someone suffering anaphylactic shock. Each state must pass the bill. North Carolina was one of the first states to pass the bill.

I was also able to get the Army, Navy, Air Force, Marines, and Park Services to include insect sting kits

containing epinephrine in their medical kits. The American Academy of Allergy and the American College of Allergy have passed special resolutions supporting this. Also, the past presidents of the American Academy of Family Practice and of the American Academy of Pediatrics have written letters of support.

The reason I began my campaign for legislation was a mother here in Asheville who called me to report that her son, who had had a previous reaction, was seen in the Emergency Room and given antihistamine by the physician to prevent anaphylaxis from the next sting. He was fishing one day and was stung again. He died.

Another call came from a lady from Florida who told me of her handicapped son who was severely allergic to bees. He had had a reaction and was given an insect sting kit. She explained this to the boy's bus driver. However the driver told her that due to state law, he was unable to give any type of injection or medication. The mother and I have been working to have Florida change this so even bus drivers can legally administer epinephrine. She asked me to appear before the Senate Subcommittee of Health Care and Health Rehabilitations Services.

Dr Donald Cook of the American Academy of Pediatrics and School Health Committee wrote:

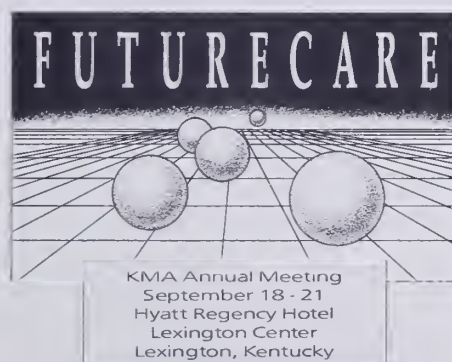
The problem is this: (1) Very few school people, parents, or physicians are aware of the potential seriousness of the problem. (2) If they did, they wouldn't know what to do. (3) If they did know what to do, they would be afraid to do it; or (4) Their school administrators would prevent them from doing it for fear of law suit.

I hear at lectures I give of people who have had severe reactions previously and who were only given an antihistamine to carry. This is not effective and will not save their lives.

People do die from anaphylactic shock reactions to insect stings, and I am convinced that there are many more not documented because of misdiagnosis.

Claude A. Frazier, MD  
Asheville, NC 28801

*On November 16, 1993, the American College of Allergy and Immunology recognized Claude A. Frazier, MD, with a special Award of Appreciation "for his outstanding efforts in educating the public about the life-threatening dangers of insect allergy." Dr Frazier is the author of INSECT AND ALLERGY: And What To Do About Them, (University of Oklahoma Press), and INSECT ALLERGY: Allergic and Toxic Reactions to Insects and Other Arthropods, (Warren H. Green Publishing).*





# AWARDS NOMINATIONS

The KMA Awards Committee is accepting nominations for the two highest awards the Association presents. The Distinguished Service Award is presented annually to a member of the Association based on the following criteria:

- Contributions to organized medicine (including membership in county society, attendance of county and state meetings, service on committees, leadership as an officer, etc.)
- Individual medical service
- Community health, education and civic betterment
- Medical research

The nominee may qualify on any one or all combinations of these points. Reasons for the nominations should be clearly stated.

The Kentucky Medical Association Award is presented to an outstanding lay person in Kentucky each year in honor of his or her outstanding accomplishments in the field of public health and/or medical care.

The Awards Committee will have the responsibility to choose recipients of the KMA Distinguished Service Award and the Kentucky Medical Association Award. Any county society or individual member may suggest nominees to the committee.

The awards are presented at the President's Luncheon during the annual meeting.

## AWARD NOMINATION FORM

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Place: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_

Children: \_\_\_\_\_

☐ Distinguished Service  
Award (Physician)

☐ KMA Award  
(Lay Person)

Education: \_\_\_\_\_

Military: \_\_\_\_\_

Membership in Professional Organizations: \_\_\_\_\_

Membership in Civic Organizations: \_\_\_\_\_

Honors and Awards: \_\_\_\_\_

(Describe nominees qualifications and other pertinent information which the Awards Committee may consider in making its decision.)

Name of Person or Group Submitting Nomination: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: (Home) \_\_\_\_\_

(Office) \_\_\_\_\_

Please fill in and mail to: KMA, Attn: Awards Committee, 301 N Hurstbourne Pky, Ste 200, Louisville, KY 40222

Deadline for receiving nominations is July 15.

# KMA Alliance Annual Convention, April 10 – 12

All physician spouses are invited to attend the 73rd Annual Convention of the Kentucky Medical Association Alliance which will be held in Somerset, Kentucky, April 10, 11 & 12. All business meetings will be held at the Holiday Inn on So Hwy 27. Somerset is located in south central Kentucky on the banks of beautiful Lake Cumberland.

We will celebrate the accomplishments of the year and witness the installation of the new officers for 1995-96. Members are invited to attend all sessions. Monday will be committee meetings and the Pre-Convention Board Meeting, followed with a trip by houseboat on beautiful Lake Cumberland and a cookout. Entertainment for the evening will be "Appalachian Music" by the Compton Family.

The House of Delegates will meet on Tuesday and discuss the business of the Alliance, followed by a luncheon honoring our past presidents. Jo-Ann Daus (Arthur), President of the Southern Medical Association Auxiliary, and Sharon Scott (James), American Medical Association Alliance President-Elect, will be talking to the Alliance on Southern's programs and the AMA Alliance's plans for the future. Guest speaker at the luncheon will be Bob Park, a humorist from Henderson, Kentucky.

Tuesday evening there will be a reception and dinner for the new President and her Board. Special events for Tuesday evening will be the presentation of the AMA-ERF checks to the representatives of the University

of Kentucky and University of Louisville medical schools. This has been our best year thus far in collections for AMA-ERF.

Guest speaker for the installation dinner will be Dr Robert Goodin, KMA President. Our finale will be the installation of the 1995-96 officers by AMAA President-Elect, Sharon Scott.

Officers are:

Marla Vieillard (Louis), President  
Boyd

Ruth Ryan (John), President-Elect  
Jefferson

Betty Housman (Lloyd),  
V-President/AMA-ERF  
McCracken

Barb Haas (Joseph),  
V-President/Membership  
Northern Kentucky

Jan Crase (James),  
V-President/Legislation  
Pulaski

Aroona Dave (Uday),  
V-President/Health Promotions  
Hopkins

Debbie Bruenderman (David),  
Secretary  
Jefferson

Nancy Swikert, MD (Don),  
Treasurer  
Northern Kentucky

The Alliance needs the support and membership of every physician spouse in order to give the greatest support possible to the physicians of Kentucky. The mission of the Alliance is to work in coalition with the Kentucky Medical Association to promote quality health care and sound legislation. If you haven't joined our organization, I am asking you to join now. Our membership team has worked very hard this year



and their efforts have been rewarded by obtaining many new members. Even though some of you reside in counties that do not have an organized alliance, you can join as a member-at-large.

There have been many volunteer hours provided by members of this organization to work on anti-violence programs, health education programs to teach children about tobacco, behavior modification, safety in the home and school, think first programs, and many more. All of these were designed and implemented by physician spouses volunteering their time and talents to help our youth have a happier and safer future.

This has been a rewarding year for me, and I am honored that I have had the privilege to serve as President of the KMA Alliance. I want to thank the KMA staff and leadership for their support and help.

*Joyce Clark*

**KMA Alliance President**





IF THE NOISE COMING

FROM NEXT DOOR

WITH LOUD MUSIC,

YOU'D DO SOMETHING

ABOUT IT.

It's not a private family matter. Every nine seconds another woman is beaten by her husband or boyfriend. And unless we all work together, it's never going to stop. For information about how you can help stop domestic violence, call 1-800-777-1960.

THERE'S **NO** EXCUSE

for Domestic Violence.



Family Violence  
Prevention Fund

# KMA DOMESTIC VIOLENCE AWARENESS SEMINAR

May 20, 1995  
9:00 a.m. - 2:00 p.m.  
Hyatt Regency Hotel, Louisville

» » » *Target Audience: Physicians, Nurses, and Other Health Care Providers*

## SPEAKERS:

BARETTA R. CASEY, MD, Chair, KMA Subcommittee on Domestic Violence

GEORGE R. NICHOLS, II, MD, Office of Medical Examiner

LEAH H. DICKSTEIN, MD, University of Louisville, Department of Psychiatry

KATHY FREDERICH, Adult Protection Specialist, Adult Protective Services, Cabinet for Human Resources

RICHARD F. JONES, MD, Farmington, Connecticut, Past President, American College of Obstetrics and Gynecology

THE KENTUCKY MEDICAL ASSOCIATION DESIGNATES THIS CONTINUING MEDICAL EDUCATION ACTIVITY FOR 4 CREDIT HOURS IN CATEGORY 1 OF THE PHYSICIAN'S RECOGNITION AWARD OF THE AMERICAN MEDICAL ASSOCIATION.

THE KENTUCKY MEDICAL ASSOCIATION IS ACCREDITED BY THE ACCREDITATION COUNCIL ON CONTINUING MEDICAL EDUCATION TO SPONSOR CONTINUING MEDICAL EDUCATION FOR PHYSICIANS.

For registration information, contact the KMA at (502) 426-6200. The fee is \$35.00 prior to May 10, and \$50.00 thereafter.

For information on obtaining nursing contact hours, contact Mr. Jack Kelly, KMA Headquarters.

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## EDUCATIONAL OBJECTIVES

During the seminar, speakers will:

- ⇒ Discuss and stress the need for health care providers to know the signs and symptoms of spouse abuse in their patients.
- ⇒ Discuss the importance of documentation and reporting of suspected abuse.
- ⇒ Review statistics about victims of domestic violence and the role of the provider to help lower the statistics.
- ⇒ Review the involvement of health care providers in the legal arena when reporting suspected abuse in patients.
- ⇒ Discuss communication techniques and questions which are essential for discussing domestic violence with patients.



# APPLICATION FOR SCIENTIFIC EXHIBITS

Kentucky Medical Association  
1995 Annual Meeting

Lexington Center, Lexington, KY  
September 19-21

1. Title of exhibit \_\_\_\_\_
2. Name(s) of exhibitor(s) \_\_\_\_\_  
Address \_\_\_\_\_  
Professional title \_\_\_\_\_
3. Institution if other than exhibitor \_\_\_\_\_
4. Amount of backwall footage required \_\_\_\_\_  
(The draped booth has 4' side walls. This footage should not be included in backwall footage required). TABLE DESIRED? \_\_\_\_\_  
(Table 2' deep x width of backwall (footage) ELECTRICAL OUTLET DESIRED? \_\_\_\_\_
5. Will summary printed matter be available or obtainable for the interested physician? \_\_\_\_\_
6. Indicate sources of assistance provided to you in connection with this exhibit \_\_\_\_\_
7. Has this exhibit been displayed before? If so, when & where? \_\_\_\_\_  
\_\_\_\_\_
8. It is required that you attach a rough sketch or photograph and a brief outline of your exhibit to include: (a) content of the presentation and (b) the method, eg, equipment to be used.

Date \_\_\_\_\_

Signature of Applicant \_\_\_\_\_

Fill out and mail to:  
RICHARD A. KIELAR, MD, Chairman  
Scientific Exhibits Committee  
Kentucky Medical Association  
301 N Hurstbourne Pky, Ste 200  
Louisville, KY 40222

The Kentucky Medical Association welcomes and supports scientific exhibits as a facet of continuing postgraduate education.

Applications for space should be received before June 15, 1995.

- COMMERCIALISM, such as utilizing the name of sponsoring organization or facility, either on the exhibit or in printed materials, is PROHIBITED.
- KMA provides, without cost to the exhibitor, one 2 ft. table, bracket lights and a title sign.
- Spotlights, view boxes, furniture, decorations, etc, may be furnished by the exhibitor or may be rented, if desired, by applying directly to the George E. Fern Company, 3752 Crittenden Dr, Louisville, Kentucky 40209.
- Transportation and erection costs are the responsibility of the exhibitor.
- Exhibit must be attended during intermissions to answer physicians' questions. It is also desirable to have someone in attendance throughout the program.
- Equipment which will create noise must not be used during the general sessions and, at other times, must be controlled by head or earphones or a muffling device.
- Exhibit must be dismantled and removed by 4:00 PM, Thursday, September 21, 1995.
- Exhibit space is strictly limited to footage and space allotted. No exhibit may extend into the aisle.

Lexington Center and the Kentucky Medical Association or its agents cannot guarantee against loss or damage and will assume no liability for damages nor guarantee the exhibitor against loss of any kind. The exhibitor agrees, with the Association, to be responsible to the Lexington Center for damages that may occur as a result of the exhibitor's use of the facility.

## 1995

## APRIL

**28-May 5 — 54th Annual American Occupational Health Conference, Sands Expo and Convention Center, Las Vegas, NV.** Contact: ACOEM, 55 W Seegers Rd, Arlington Heights, IL 60005; 708/228-6850; FAX 708/228-1856.

## MAY

**2 — Third Annual Spring Banquet of Jackson Purchase Cardiovascular Society, Country Club of Paducah, Paducah, KY.** Sponsored by Western Baptist Hospital. Contact: Martha Hinton, Education Office, Western Baptist Hospital; 502/575-2732.

**12-13 — Contemporary Pediatrics for the Primary Care Physician, Hyatt Regency Hotel, Lexington, KY.** Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

**21-26 — 26th Annual Family Medicine & Primary Care Review — Session II, Hyatt Regency Hotel, Lexington, KY.** Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

## JUNE

**8-10 — Advanced Life Support in Obstetrics, Holiday Inn North, Lexington, KY.** Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

**9-11 — American Brain Tumor Association Brain Tumor Symposium, Ramada Hotel (near O'Hare Airport).** Contact: ABTA Symposium, 2720 River Rd, Suite 146, Des Plaines, IL 60018; phone 1/800/886-2282.

## JULY

**12-16 — Internal Medicine Board Review, Radisson Plaza Hotel, Lexington, KY.** Contact: Office of Continuing Medical Edu-

cation, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

## OCTOBER

**6-17 — Allergy Abroad '95, The Ritz-Carlton Hotel, St. Louis, MO.** Sponsored by Washington University School of Medicine. Contact: CME Office, Washington University School of Medicine, Campus Box 8063, 660 South Euclid Ave, St. Louis, MO 63110-1093; 314/362-6893; 800/325-9862.

## NOVEMBER

**5-10 — 26th Family Medicine and Primary Care Review — Session III, Hyatt Regency Hotel, Lexington, KY.** Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

**17-18 — Perinatal/Neonatal Symposium, Radisson Plaza Hotel, Lexington, KY.** Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

## No gain.No pain.

Keeping your weight at a moderate level may scale down your risk of heart attack. So maintain a healthy diet and lighten up on your heart.





## President Robert R. Goodin, MD, Testifies on Medicaid Cuts and the DOP Program

*On Tuesday, February 21, 1995, Robert R. Goodin, MD, testified in Frankfort on behalf of the Kentucky Medical Association at the public hearing on proposed regulations pertaining to the Medicaid cuts and the Discount Option Program.*

*Dr Goodin presented oral comments on both regulations and submitted written comments including the legal complaint filed in the KMA lawsuit in the US District Court, Frankfort Division.*

*The following are excerpts from Dr Goodin's testimony.*

### Medicaid Cuts

**"**L et me preface my remarks by emphatically stating that in my opinion, and in the opinions of hundreds of my colleagues with whom I have communicated on this subject, the future of Kentucky's Medicaid is gravely threatened by this regulation . . . Despite recent stories reported by the media on the number of physicians that have officially withdrawn from Medicaid, if the cuts proceed, the danger of massive withdrawal is real. We have already seen situations in Northern Kentucky where physicians, acting individually and on their own initiative, have withdrawn from the program and

literally hundreds more have communicated to KMA that they intend to wait until the pending litigation in the 6th Circuit Court of Appeals is resolved before making a decision. Additionally, there are hundreds of physicians that have not withdrawn but, rather, are simply not taking new Medicaid patients into their practices.

The bottom line is this — CHR has violated federal Medicaid laws in implementing these cuts. They are illegal and, more importantly, if left to stand, will serve to dismantle the Medicaid program as we know it. All physicians may not drop out, but their participation may be limited. The end result may well be a less effective Medicaid program rendering medical care to Kentucky's indigent population."

### Discount Option Program

"The enabling legislation for DOP included in HB 250 states in pertinent part that 'CHR shall establish a program as a provider of last resort which permits persons with family incomes below two hundred percent (200%) of the federal poverty level to purchase THROUGH THE MEDICAID PROGRAM, health services covered by Medicaid from participating providers at the same rate Medicaid pays for the service . . .'

The proposed DOP regulation

omits some of the crucial elements specifically set out in HB 250. As many other provider groups will testify, DOP was characterized during the 1994 General Assembly as a 'buy-in' program, not unlike the State employee insurance buy in addressed in Section 93 of HB 250.

It is apparent that this draft of the regulation ignores the specific mandate of HB 250 that services be purchased THROUGH MEDICAID and is therefore not a true buy-in program. KMA would suggest amending the regulation to make it truly a program of last resort where a person who meets income tests and who demonstrates an inability to obtain insurance coverage can 'buy into' Medicaid. It is KMA's belief that this would require approval from the Health Care Financing Administration (HCFA), and that CHR should seek such approval prior to implementing these regulations. Not only would this conversion to a 'buy in' comport with Legislative intent, it would also assure some measure of payment to those who provide medical services pursuant to DOP."

*The KMA will provide updates on both regulations and the lawsuit on the Medicaid cuts as more information becomes available.*

## Ardis D. Hoven, MD, Named by HHS Secretary Shalala to Serve on PPAC

**U**S Department of Health and Human Services Secretary Donna E. Shalala has announced the appointment of KMA Immediate Past President, Ardis D. Hoven, MD, as a member of the Practicing Physicians Advisory Council.

Dr Hoven and two other appointees, Marc A. Lowe, MD, Seattle, Washington, and Richard A. Bronfman, DPM, Little Rock, Arkansas, were selected from more than 80 nominees to replace three members whose terms expired on February 28. Members are appointed to 4-year terms. The new chairman is neurologist Kenneth M. Viste, Jr, MD, from Oshkosh, Wisconsin, who has been a council member since March 1994. He will serve a 2-year term as chairman.

When making the appointment, Secretary Shalala said, "The three new members are providers who have given high-quality care for many years to Americans living in urban areas. I look forward to working with them and Chairman Dr Viste, who treats

patients living in a rural region of Wisconsin. The advisory council provides valuable input into improving the department's regulatory process."

Bruce C. Vladeck, administrator of the Health Care Financing Administration, added this comment, "These three talented individuals, who are new to the council, are joining with others in taking time away from their busy practices to help simplify the process of bringing quality health care to Medicare beneficiaries."

The 15-member council, established by Congress, meets quarterly to advise the HHS Secretary on proposed changes in regulations and carrier manual instructions that relate to physicians' services under Medicare.

Under the law, the advisory council must include both Medicare participating and nonparticipating physicians, and physicians practicing in rural and underserved urban areas. All members must have submitted at

least 250 claims for physician services under Medicare in the previous year.

At least 11 members must be physicians licensed to practice medicine and surgery by the state in which they practice. The other four members may include dentists, podiatrists, optometrists, and chiropractors.

This is a prestigious and important appointment for Dr Hoven, a Lexington specialist in internal medicine with a subspecialty in infectious diseases and with a large practice in AIDS-related cases.

Dr Hoven's commitment to her profession also includes current service as a delegate to the American Medical Association and membership on the AMA's Advisory Committee on Group Practice. Since 1993, she has been a member of the Kentucky Governor's AIDS Policy Advisory Council and the Governor's Task Force on Domestic Violence.

*KMA*



# King Will and the Foul Humours: A Fable for Reform

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*Editor's Note: Following is a report given by Robert E. McAfee, MD, AMA president, at the 48th Interim Meeting of the AMA House of Delegates, December, 1994.*

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Ladies and gentlemen, over the course of the last two years, we've been asked to believe several fairy tales in the name of health system reform. So today, I'd ask your indulgence as I tell one last fairy tale.

I'd like to tell you the story of King Will and the Foul Humours.

Once upon a time, there were a King and Queen who lived in a big, white castle, surrounded by a big, black fence, that was regularly patrolled by knights wearing dark visors.

Before King Will had become King, he lived in the forest, where he took from the rich and gave to the poor. This made him quite popular — especially with the poor — but he mistook his popularity for wisdom, and no sooner had he moved into the white castle than he began searching throughout the Kingdom for problems to solve.

He said to the Queen: "Queen (for he always addressed her in this manner), "do you perceive any problems in the Kingdom that crierst out for solutions?"

The Queen replied: "Are you kidding? The knighthood could use a little more diversity. The plague is making a comeback. And every time you take your exercise, you can't stay

away from the butcher shop."

Now, the King ignored this last comment, but the problem of the plague seized his mind.

He knew that many of his subjects were unable to see the Wizards — those Doctors of Physics who ministered to the ill. All he knew was that the tithe for having their humours checked was rising faster than the Consumer Price Index.

But the King also knew that the

---

*"I believe we can write a Fairy Tale ending if we never forget that the true power of our magic is not what's under our hats, but what's in our hearts."*

---

magic of the Wizards was unsurpassed. Citizens from neighboring kingdoms would travel many leagues just to see them. And the vast majority of his subjects were well contented with their system of care, and could see a Wizard almost whenever they wanted to.

The King mulled over his dilemma — he was famous for mulling and wonking — and finally, he came to a decision. So he said to the Queen: "It is up to us to give the people the health care they deserve."

Now a strange thing happened. The Queen might well have turned to

the Wizards, who themselves had been discussing this problem and recommended remedies for many years. But instead, she summoned a noted sorcerer from a far away land, Ira of the Unruly Hair. And Ira gathered a legion of fellow sorcerers, and convened them in a secret Star Chamber, a place so dank and dark no light could enter or escape.

They labored while the Spring blossoms scented the trees. And they labored while the sun ripened the fruit on those trees. And they labored while the leaves on those trees began to fall to the earth. Then, one day the Queen sent a crier throughout the Kingdom to announce that Ira of the Unruly Hair had indeed produced a mighty plan and it would be wondrous to behold.

They gathered every beast of burden in the Kingdom, all the oxen and horses and mules, and they hitched them to the machine on which they had placed the great plan — for the plan was not only great in inspiration but great in size — and they hauled it to the big, white castle and presented it to King Will.

And King Will, who was chewing on the drumstick of a great wonk, placed his seal upon the plan.

Now, on a hill looking down on the white castle was a great hallowed hall with a round dome. And in that hall were knights of renown from every other castle in the Kingdom. They were divided roughly into two camps, and the shields of one camp bore the sign of the donkey, and the shields of the other the sign of the elephant.

It was these knights' job to decide the laws of the land, but in truth, most of their days were spent in their favorite sport, which was jousting. The leader of the donkeys, Sir George of the Land of Lobster, was one of the most feared jousts. He said: "Let them bring us the plan of King Will, so we can make it the law of the land."

And the oxen and horses and mules began to haul the mighty plan from the white castle to the hall on the hill. But a hew and cry went up throughout the hall almost as great as during the debate over where the knights could tie up their horses.

And the leader of the elephants, Sir Bobdole of the Land of Corn, who was famous for his skill with the lance, spoke: "Not so fast," said Sir Bobdole. "That plan has more fat than a roasted boar."

For it so happened that the donkeys and the elephants had opposing views on the health care of the people. The donkeys believed that the King and the knights should design the system, and decide what kind of training should be given to the Wizards and which Wizards the people could see. And the donkeys believed if the subjects would pay their tithe to them — they could fix the system.

But the elephants said the people were tithed too much and the money was wasted on things like midnight falconry. And they said the King and the great hall should stay out of it. And they accused the donkeys of being beholden to a knight of yore, Sir Franklin of the New Deal.

So the knights of the donkeys and the knights of the elephants devised their own plans: Sir George of the Land of Lobster, Sir Chafee of Rhodes, Sir Stark of Fortney, Sir Teddy of Camelot and others. But the champion of one plan, Sir Rosty of the Windy City, was injured when he was out delivering a gift to a subject and fell into a moat.

But these plans, too — five in all

---

*"The people will continue to receive the best care on Earth when they demand nothing less.*

*We wizards must never forget that we can deliver that care only if we're united in our vision, our voice and our leadership."*

---

— were also placed on great machines and hauled out to be viewed by the people. And the knights returned to their jousting.

And now thick fog hid the sun, and thunder rent the air, and torrents of rain turned the land into mud, and the plans of King Will and all the plans of the great Hall got bogged down.

All the while the Wizards offered advice and counsel on the health of the people. And the people heard them and gave the Wizards their confidence. But the King and Queen and many in the Great Hall gave the people only the cold shoulder and the deaf ear.

Now there arose in the land a new evil that further threatened the health care of the people.

One day, five great dragons from the Kingdom of Insurers appeared in the sky, and encamped in every corner of the Kingdom. And on their wide wings were markings sinister and strange. One had what looked like the giant rock of Gibraltar.

Another had what looked like a great umbrella of crimson. Still a third was marked with a small cartoon beagle.

People began to call them the Big Five, and they breathed fire, and made a bellowing that was terrible to hear, and were in general

unmannerly. And they began making forays across the land, swooping down upon unsuspecting subjects and herding them into their own regions.

They swallowed up entire villages. And they plucked up select Wizards, and demanded that they tend only to the citizens they had corralled, and none other. And the citizens raised up a cry because they could no longer see the Wizards who had so carefully watched over them.

But as the dragon's plunder continued, their appetites, rather than be sated, grew only more ravenous. It was rumored that some dragons even tried to eat some of the others. And clouds darkened the sky and a great indigestion struck the bowels of the people, and they were so afraid.

Ladies and gentlemen, most fairy tales end with everyone living happily ever after.

And for that to happen here, you might expect that a white knight would appear to slay the dragons and knock some sense into the King, the Queen and the knights of the hall on the hill.

But the ending to this story has yet to be written.

The great plans of the King and Queen and all the knights of the Hall got bogged down under their own weight. The wheels came off the machines, and all the King's horses and all the King's men . . . well, you're already familiar with that verse.

And as a result, many knights lost their shields and left the great hall forever — although most went on to join the newly formed Guild of Lobbyists. Some who remained were hoping to fix the Kingdom's health system by mixing up a special magic potion. Its main ingredient was Eye of Newt.

Most of the knights, however, just went back to their jousting.

As for King Will and his Queen, the whole experience was enough to make them wish they were back in their forest, in their house surrounded by rushing white water.



The King has recently taken to traveling to foreign lands. But he never misses a chance to remind the Queen that you just can't trust a sorcerer.

What remains are the Wizards and the people — the true heart and soul of any health care system.

The people will continue to receive the best care on Earth when they demand nothing less.

We Wizards must never forget that we can deliver that care only if we're united in our vision, our voice and our leadership.

And, I believe we can write a Fairy Tale ending if we never forget that the true power of our magic is not what's under our hats, but what's in our hearts.

And for allowing me the privilege to be your chief Wizard for a year — I thank you very much.

**Robert E. McAfee, MD**  
**AMA President**

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You support them.  
You fight  
for them.**



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and fights for you.**

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**American Medical Association**  
Physicians dedicated to the health of America



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---

## PEOPLE

**Suzanna Park, MD**, University of Kentucky, has been chosen as a George Ginsberg AADPRT/Charter Fellow for 1995. This is the sixth year for this fellowship made possible by the Charter Medical Corporation. This annual award is given to seven outstanding residents interested in education and teaching. As Chief Medical Resident in 1988-89 Dr Park was chosen as Best Resident Teacher for the UK Medical Center as well as the Department of Medicine Resident Teacher of the Year.

**Robert L. Nold, Sr, MD**, a Louisville family practitioner, recently received a Departmental Outstanding Alumnus Award from the University of Louisville School of Medicine. Dr Nold was recognized for outstanding service to the Department of Family Medicine and received his award from **Salvatore J. Bertolone, MD**, President of the Medical School Alumni Board of Governors. Dr Nold currently serves as President of the Kentucky Academy of Family Physicians.

**Ludy Linger, MD**, has been chosen by the Area V Council of the American Psychiatric Association for the William Sorum Award for residents. This award was established to honor the resident within each Area that has made the most notable progress in resident activities, involvement, participation, or representation in the APA.

**Edwin Earl Gaar, MD**, has received the Thomas Calhoun Award for outstanding teaching from the University of Louisville School of Medicine Class of 1994. He has received the Golden Apple from U of L students for the past 3 years.

**Villiam Briscoe, MD**, has been appointed by Governor Brereton

Jones to sit on the Kentucky Board of Medical Licensure. He replaces **Frank Gaines, MD**, a longtime member of the Board.

**John W. Derr, Jr, MD**, was recently elected secretary-treasurer of the Kentucky Society of Plastic and Reconstructive Surgeons and president of the Louisville Society of Plastic and Reconstructive Surgeons.

**Robert D. Fechtner, MD**, a Louisville ophthalmologist; **Julio Ramirez, MD**, a Louisville infectious disease specialist; and **Mark A. Wilson, MD**, a Louisville general surgeon, were among the 10 assistant professors recently chosen as winners of U of L's Young Investigator Award.

Dr Fechtner's nomination described him as among the "most knowledgeable individuals in the world in optic nerve imaging techniques." Dr Ramirez' nomination noted that he has done medical research "that is earning him a respected reputation among his peers both nationally and internationally." Dr Wilson, while still a lecturer in the surgery department, was a physiology and biophysics graduate student at U of L. He received the award for graduate student research and was co-winner for best-quality presentation at the Price Institute of Surgical Research symposium.

**Jon M. Miller, MD, PhD**, a senior psychiatry resident at the University of Louisville, has been named a Henry P. Laughlin Fellow by the American College of Psychiatrists.

**C. Russell Hoffman, Jr, MD**, a Louisville internist, and **Philip G. Morrow, MD**, a Louisville endocrinologist, have received the American Diabetes Association Certificate of Recognition for a quality patient education program. Their practice is one of six in the US to

achieve this recognition for quality diabetes education.

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## UPDATES

### KMA Domestic Violence Awareness Seminar

The KMA Subcommittee on Domestic Violence has planned a Domestic Violence Awareness Seminar for Saturday, May 20, 1995, in the Regency Ballroom of the Hyatt Regency Hotel in Louisville. The program will run from 9 AM to 2 PM, and will feature **Baretta R. Casey, MD**, Chair, Subcommittee on Domestic Violence, who will moderate the program; **Richard F. Jones, MD**, Past President, American College of Obstetrics — Gynecology, who will be the luncheon keynote speaker; **George R. Nichols, II, MD**, Office of the Medical Examiner; and **Leah J. Dickstein, MD**, University of Louisville Department of Psychiatry.

The registration fee for all health care personnel is \$35.00 before May 10, 1995, and \$50.00 after May 10, 1995. You can register by calling 502/426-6200.

### Domestic Abuse: Does patient confidentiality inhibit reporting?

Most physicians know the statistics, but the question often arises, "doesn't confidentiality of my patient keep me from reporting?"

As a surprise to many, the answer is no. In cases of suspected child or adult abuse, according to KRS 209.030, if a physician has reasonable cause to suspect that a patient has been a victim of abuse, the physician is required by law to submit a written



or oral report immediately to the Department for Social Services. Physicians may call the Adult/Child Abuse Reporting Hotline at 1-800/752-6200.

Reporting of suspected spouse abuse is not a break of the physician-patient privilege. The General Assembly in KRS 209.050 specifically grants physicians and other health care providers immunity from civil or criminal liability for filing a report of suspected abuse, neglect, or exploitation of an adult. The General Assembly has imposed harsh penalties for any physician or health care provider who fails to file a report of abuse. Any physician who fails to report may be found guilty of a Class B misdemeanor and may face a criminal fine of \$500 and up to 180 days in jail.

Physicians are an important key to ending this crime, as are police, prosecutors, and the judicial system. Physicians must assume this responsibility even though medical professionals have not necessarily been trained to do so.

### **FDA Approves Havrix, the World's First Hepatitis A Vaccine**

SmithKline Beecham Biologicals has announced that the US Food and Drug Administration (FDA) has licensed the marketing of Havrix® (Hepatitis A Vaccine, Inactivated), the world's first hepatitis A vaccine. The vaccine is indicated for active immunization in people at risk of exposure to hepatitis A virus, including travelers to Mexico, parts of the Caribbean, South and Central America, Africa, Asia (except Japan), the Mediterranean basin, Eastern Europe, and the Middle East.

### **Sexual Harassment Guidelines Available From the AMA**

A 19-page report entitled, "Guidelines

for Establishing Sexual Harassment Prevention and Grievance Procedures," is available from the American Medical Association.

Developed by the AMA Women in Medicine Advisory Panel and the AMA Office of the General Counsel, the guidelines are designed to help medical schools, residency programs, and other institutions address issues of sexual harassment of medical students and physicians. For a copy of the AMA guidelines, call 1/800/262-3211.

### **Surgeons Perform Double-Lung Transplant**

The University of Louisville reports that surgeons **Robert D. Dowling, MD**, and **Daniel L. Miller, MD**, have performed Jewish Hospital's first double-lung transplant. The patient received the lungs in a 7-hour operation. His original set of lungs had been damaged by occupational exposure to toxic chemicals.

According to the University, the patient was alert and resting in stable condition within a few days. "Our patient is doing very well after only one week," Dr Dowling said. "He is already breathing easier and his long-term prognosis is excellent. We expect him to return to a full level of activity and do things he hasn't been able to do in years."

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Do The Job Is  
What Matters,  
Not How You Get There.**

The President's Committee  
on Employment of the Handicapped  
Washington, D.C. 20036

### **NEW MEMBERS**

*Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.*

#### **Fayette**

**Peter J. Gurk, MD** — FP  
3174 Custer Dr, Lexington 40502  
1989, Creighton

**John M. Iaquinto, MD** — ORS  
120 N Eagle Creek #521, Lexington  
40509

1983, Temple  
**David Kelly, MD** — N  
1677 S Prairie Cir, Lexington 40515  
1989, U of Virginia

**Lyle C. Myers, MD** — END  
3340 Brighton Place Dr, Lexington  
40509

1985, Temple  
**John A. Read, MD** — OBG  
3689 Wembley Ln, Lexington 40515  
1972, UCLA

**Michael G. Rukavina, MD** — C  
1760 Nicholasville Rd #601, Lexington  
40503  
1987, LSU

**Ronald Schubert, MD** — FP  
2101 Nicholasville Rd #307, Lexington  
40503

1984, Spartan Health Sciences U  
**Joseph G. Werner, MD** — ORS  
135 E Maxwell #208, Lexington 40508  
1988, U of Louisville

#### **Fulton**

**William A. Smith, Jr, MD** — IM  
400 Third St, Fulton 42041  
1979, U of Kentucky

#### **Greenup**

**Gabriel R. Pereira, MD** — AN  
126 Butternut Ln, Ashland 41102  
1985, Amer Univ of the Caribbean

#### **Henderson**

**James E. Buckmaster, MD** — FP  
2606 Zion Road #A, Henderson 42420  
1984, U of Kentucky

**Harrison**

**Todd W. Ussery, MD** — AN  
RR 1, Box 476A, Cynthiana 41031  
1990, Med Col of Georgia

**Jefferson**

**Matthew Bessen, MD** — C  
250 E Liberty #1001, Louisville 40202  
1982, Chicago Med Sch  
**Robert D. Blair, MD** — N  
210 E Gray St #705, Louisville 40202  
1965, Dalhouse

**Jeffrey M. Bumpous, MD** — OTO  
601 S Floyd #700, Louisville 40292  
1988, U of Louisville

**Robert D. Dowling, MD** — C  
250 E Liberty #902, Louisville 40202  
1985, U of Pittsburgh

**Susanne E. Fix, MD** — S  
1133 Cherokee Rd, Louisville 40204  
1987, W Virginia

**Steven J. Goldstein, MD** — IM  
1137 Everett Ave, Louisville 40204  
1989, Baylor

**Amitava Gupta, MD** — PS  
9300 Felsmere Cir, Louisville 40241  
1977, Maulana Azad Med Col

**James H. Hicks, MD** — PD  
250 E Liberty #301, Louisville 40202  
1973, U of Pennsylvania

**Thomas L. Matthew, MD** — TS  
1169 Eastern Pky #2266, Louisville  
40217

1985, Columbia  
**Sharon M. Maxfield, MD** — R  
12300 Ridge Rd, Anchorage 40223  
1989, Duke

**Thomas W. Miller, MD** — OBG  
207 Sparks Ave #300, Jeffersonville  
47130

**Marguerite E. Mueller, MD** — PMR  
216 McArthur Dr, Louisville 40207  
1987, U of Louisville

**Dennis M. O'Connor, MD** — ONC  
PO Box 3086, Louisville 40201  
1974, U of Virginia

**Wayne B. Tuckson, MD** — CRS  
601 S Floyd #700, Louisville 40202  
1980, Howard Univ

**George D. Weiss, MD** — S  
210 E Gray St #703, Louisville 40202  
1989, U of Louisville

**Northern Kentucky**

**Karen J. Barnes, MD** — FP  
40 Fox Chase Dr #8, Southside 41071  
1982, U of Kentucky

**Hien Tuan Le, MD** — EM  
619 Braddock Ct, Edgewood 41017  
1990, U of Kentucky

**Neal J. Moser, MD** — IM  
6147 Kingsgate Dr, Burlington 41005  
1988, U of Kentucky

**In-Training****Fayette**

**Mary H. Baesler, MD** — FP  
**Maqbool Halepota, MD** — IM

**Jefferson**

**Martin L. Grossman, DO** — P  
**Ethel P. Larosa, MD** — PD  
**Eric J. Lentsch, MD** — S  
**Tracy L. Ragland, MD** — PD

**DEATHS**

**Oris Aaron, MD**  
**Columbia**  
**1909-1995**

Oris Aaron, MD, a retired general practitioner, died January 6, 1995. He was 85. Dr Aaron was a 1939 graduate of the University of Louisville School of Medicine and a life member of KMA.

**Jesse M. Hunt, Jr, MD**  
**Wickliffe**  
**1922-1995**

Jesse M. Hunt, Jr, MD, a retired general practitioner, died January 30, 1995. He was 72. A 1949 graduate of the University of Louisville School of Medicine, Dr Hunt was a life member of KMA.

**Lamar C. Meigs, MD**  
**Ashland**  
**1921-1995**

Lamar C. Meigs, MD, a retired pathologist, died February 5, 1995. He was 73. Dr Meigs was a 1951 graduate of the Medical College of Alabama, Birmingham, and a life member of KMA.

**IMPORTANT NOTICE**

**RELOCATION OF  
IMPAIRED PHYSICIANS  
PROGRAM**

The  
Impaired Physicians Program  
has moved  
its headquarters from the  
Kentucky Medical Association  
301 N Hurstbourne Pkwy  
to the following address:

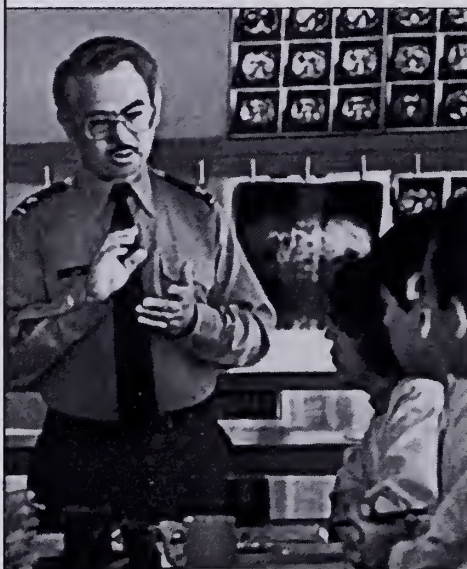
**Impaired Physicians Program**  
**9000 Wessex Place, Suite 305**  
**Louisville, KY 40222**

**New Phone Number**  
**502/425-7761**

**New Fax Number**  
**502/425-6871**



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**Word count:** Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

**Rates to KMA members:** \$10 per insertion up to 50 words, 25¢ each additional word. To non-members: \$30 per insertion up to 50 words, 25¢ each additional word.

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Kentucky Air National Guard .....	167	US Army (Reserve) .....	166

## CHANGING ADDRESS?

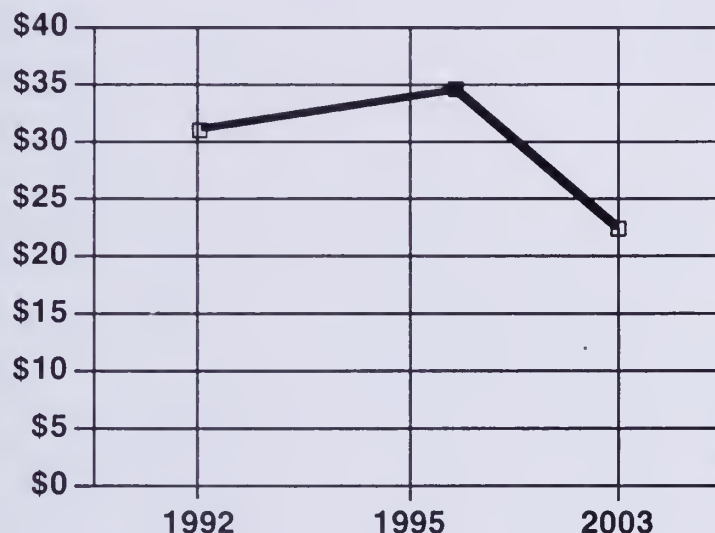
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## After inflation gross Medicare payments for a mid-level established patient office visit, CY 1992, 1995 and 2003

Current law (includes OBRA '93 cuts) in constant 1992 dollars



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Source: Based on testimony of the Physician Payment Review Commission to the House Ways and Means Committee, February 6, 1995, adjusted to reflect a three percent per year inflation increase

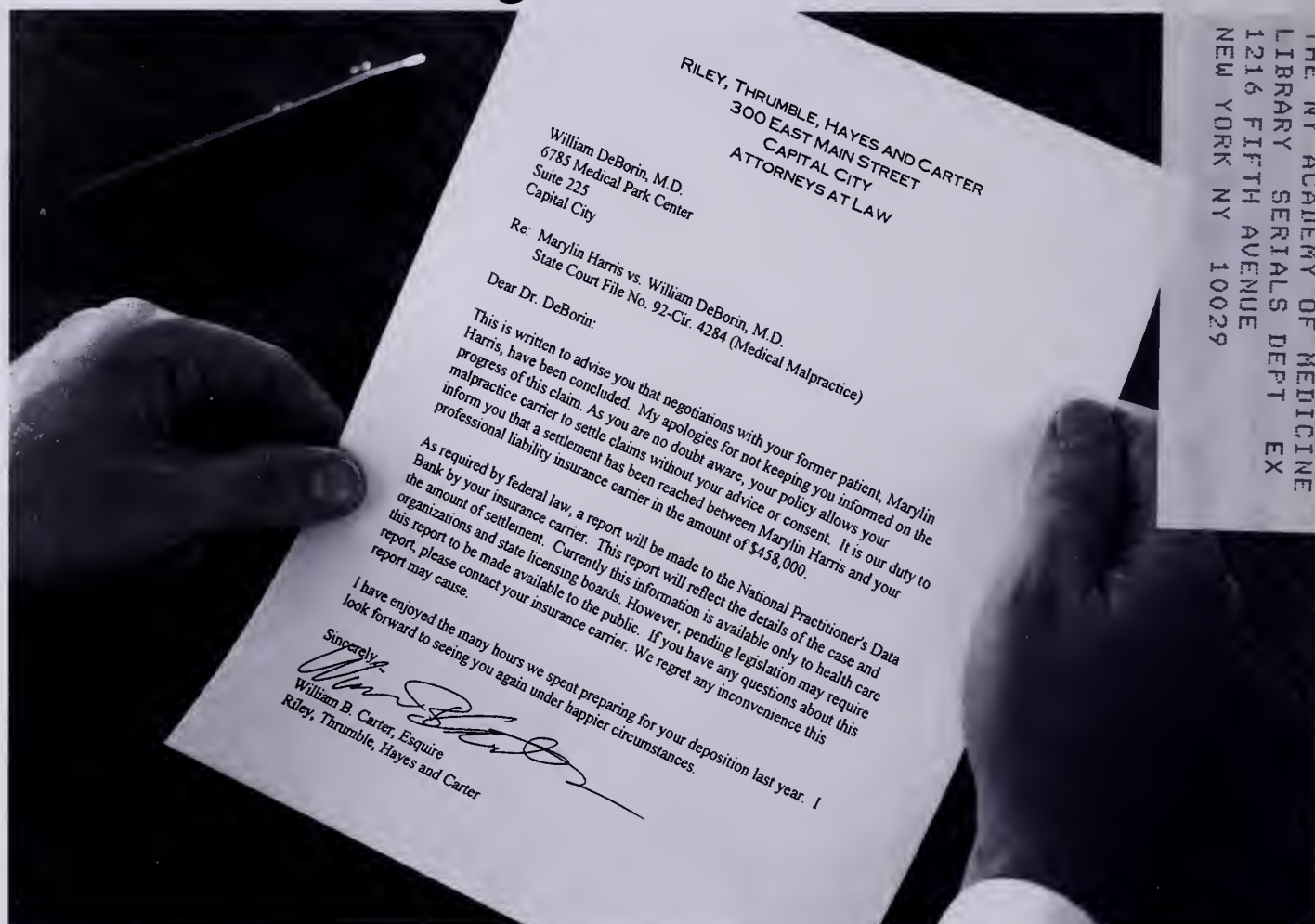
**T**his chart shows that under current Medicare cuts—taking effect over the next several years—Medicare will pay physicians 33 percent less in 2003 than the program pays in 1995. The chart illustrates payment for a mid-level office visit and assumes a three percent annual inflation rate.

Without accounting for inflation, the Physician Payment Review Commission (PPRC) testified before the House Ways and Means Committee February 6, 1995 that payments will be lower in 2003 than in 1992.

The projected drop in payments is due to the effect of the cuts on the conversion factor—the multiplier used to calculate physician fees when multiplied by the assigned relative value of the medical service.



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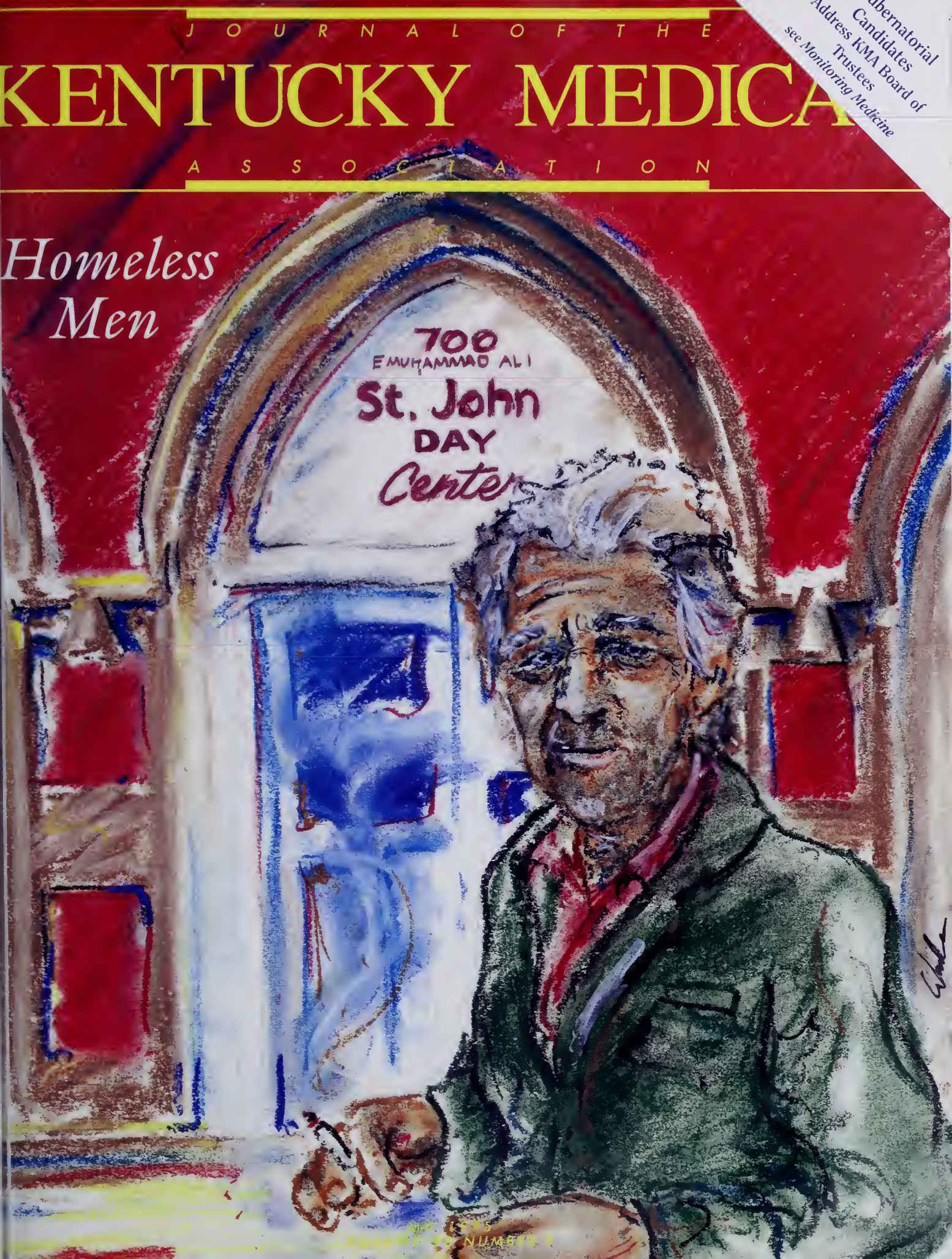
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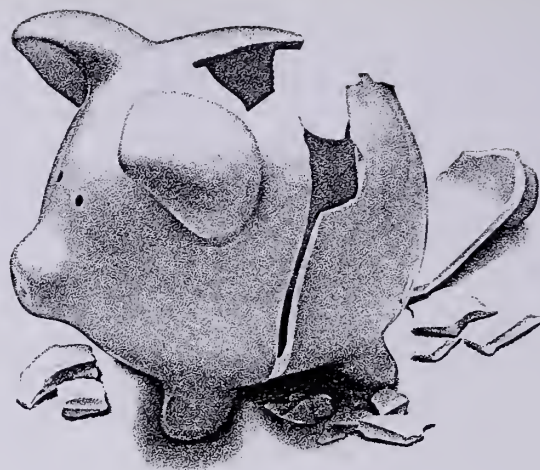
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# JOURNAL OF THE KENTUCKY MEDICAL ASSOCIATION

Gubernatorial  
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Address KMA Board of  
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see Monitoring Medicine

MAY 1995  
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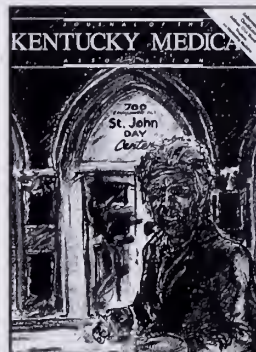
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MAY 1995

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**COVER:** The homeless present important social and medical problems in most parts of the United States, including urban areas of Kentucky, but very little is known about their quality of life or functional status. This month's feature article presents the findings of a study involving homeless men attending St. John's Day Shelter in Louisville. Artwork by Lee Wade of Louisville.

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*Robert R. Goodin, MD*

## Top Ten Concerns — Health System Reform in Kentucky 1994

In keeping with the David Letterman tradition, I will discuss my personal **Top Ten Concerns** with health system reform legislation passed in Kentucky in 1994. This is not to suggest that several good measures weren't enacted. I am confident that reforms passed in insurance and medical education will be helpful, along with fraud and abuse, medical licensure, and living will legislation. On balance, however, I believe Governor Jones and the legislature have saddled Kentuckians with the most expansive and potentially detrimental health system reform package of any state in the Union. I agree with Dr James Todd, Executive Vice President, AMA, who describes our Kentucky reform efforts as the worst in the nation.

Let me briefly discuss my **Top Ten Concerns** beginning with:

### 10. **Poor Media Coverage**

The Kentucky media, especially the state's two largest newspapers, started with incorrect premises:

1. That the high cost of health care is the doctor's fault, and
2. That our health care system needed total restructuring rather than incremental changes of the finest health

care system in the world. These erroneous premises were shared by others in Washington and Frankfort. Our media and government leaders missed a golden opportunity to educate the public about the realities of health care delivery.

### 9. **Inadequate Funding**

While passing reforms that will require new money (Health Policy Board, insurance purchasing alliance, etc) no reforms such as increased sales tax, service tax, or sin taxes were addressed. For example, if we would simply increase our cigarette tax from the nation's second lowest of 3 cents per pack to the national average of 26 cents per pack, a whopping \$110 million would be raised. (The provider tax raises \$140 million).

### 8. **More Bureaucracy**

While the Kentucky Health Policy Board will replace several functions already done by other state agencies, there are also many new areas of government control under that board. This board will wield tremendous political clout, and be subject to major pressures. I hope they can

remain independent as they approach their wide ranging responsibilities. Five million dollars is projected as annual budget for the Health Policy Board. Similar boards in other states average budgets of \$30 million.

### 7. **Mandatory Health Insurance Purchasing Alliance**

My concern here is not with the concept, but with potential inefficiency of operation. This alliance will have an appointed board of volunteer directors and could potentially control insurance purchasing for 20% or more of Kentucky citizens. Let's hope the alliance doesn't encourage businesses who already provide excellent health benefits to discard them and enroll employees into alliance plans with less choice and fewer benefits.

### 6. **No Universal Coverage**

We all agree that Kentucky's 430,000 uninsured citizens deserve to have coverage and ready access to high quality health care. I also agree with the waiver obtained by Governor Jones to enable extension of Medicaid



coverage to an additional 201,000 Kentuckians. On the other hand, since the legislature spoke very clearly in refusing to fund that expanded coverage, I strongly resent efforts to fund the additional coverage from the pockets of physicians and other providers, as is being attempted. Remember how Jones and Clinton swore to veto any bill falling short of universal coverage?

#### 5. **No Tort Reform**

The facts can no longer be disputed, even by trial lawyers. Medical liability insurance costs have risen faster than any other segment of health care costs, and yes, defensive medicine is a huge cost factor. The best independent studies of defensive medicine costs estimate \$25–35 billion annual cost in the United States. California and several other states have enacted effective tort reforms including most importantly a cap on noneconomic awards, and have shown significant control of liability costs. Governor Jones failed to follow through on his promise to work hard to get Section 54 of the Kentucky Constitution on the ballot for amendment in order to allow effective tort reform.

#### 4. **Medicaid Reforms**

The Cabinet for Human Resources has focused its efforts primarily on attacking physician reimbursement and not on the areas of alleged abuse and fraud. We were assured savings of \$200–400 million per year could come through improved efficiency of operating

the Medicaid program, reducing abuses such as transportation of patients, etc, but it seems those savings haven't been found. Meanwhile physicians received the "triple whammy" of provider tax, huge reimbursement cuts, and promises to enact the so-called DOP (Discount Option Program). Never mind that these latter two actions were described in the legislation as measures of last resort. Could it be that instead they were reviewed as measures of least resistance?

#### 3. **No Physician/Provider Input**

It is truly as unthinkable that government would attempt to reform the health care system and leave out the views of physicians as it is to reform the judiciary and leave out the lawyers. This did, in fact, happen in Kentucky. A few individuals selected by the Governor wrote legislation that looked a lot like a "Clinton-lite" bill, ignoring input from their own appointed task force's findings and the provider community. I look forward to a day when government will be willing to work with physicians so that effective health system reform can take place.

#### 2. **Government Leadership**

While spending a good deal of time in Frankfort during the 1994 legislative session, our Kentucky Medical Association Quick Action Committee members felt that both the House and Senate had strong leadership, but somehow there seemed to be little effort by the Governor to work with them. I

know that many physicians had fully expected our leadership in Frankfort to seek out the views of physicians in order to develop more workable legislation, but this simply did not take place. There was no room for effective compromising many times we sensed.

#### 1. **Cabinet for Human Resources Leadership**

The Cabinet for Human Resources has 12,000 employees with a \$3 billion annual budget, \$2 billion of that in the Medicaid program. I find it hard to believe that one person can effectively lead this Cabinet in its overall responsibilities, and also direct the Medicaid Program effectively. In my opinion, we will never have a well run Medicaid Program until there is a physician director. Our Medicaid patients deserve a program led by someone who understands patient needs and health care delivery system.

I am sure you agree that it is unfortunate that our US Congress was unable to develop and pass **appropriate** health system reform legislation, but I do applaud their courage to avoid passage of bad legislation such as the Clinton Health Security Act. It is saddening to me that when the rest of the nation votes for less government intrusion into our lives, that somehow in Kentucky we managed to legislate more government control of our health care system.

**Robert R. Goodin, MD**  
**KMA President**

# MONITORING MEDICINE

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## NEWS FOR KENTUCKY PHYSICIANS

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**W**ith the May issue of the Journal we are pleased to introduce "MONITORING MEDICINE, News for Kentucky Physicians." "MONITORING MEDICINE" will supplement the Association's reporting mechanisms by providing membership with the most recent developments in Frankfort and Washington, along with events and decisions which directly affect our patients and the profession — A. Evan Overstreet, MD, Editor

---

**I**n an unprecedented and historical event, the KMA Board of Trustees invited and interviewed the major candidates for Governor at its April 12 meeting in Louisville. Four of the five major candidates, Larry Forgy, Bob Gable, Paul Patton, and John "Eck" Rose accepted our invitation. Bob Babbage declined due to a previous commitment. Patton had to cancel at the last minute due to a meeting of the Military Base Closing Commission in Chicago which was reviewing the proposal to close Louisville's Naval Ordnance. He presented a written statement. Forgy, Gable, Patton, and Rose presented written responses to an 11-point questionnaire. Their comments have been edited, however their full responses are available to KMA members upon request.

In opening this forum, President Robert R. Goodin, MD, made the following comments:

"As Chairman Stephens noted, this is

indeed an historical event for the Kentucky Medical Association. For the first time major candidates for Governor on both sides of the aisle deem medicine and Kentucky physicians important enough to appear at this forum. Each candidate is being provided 20 minutes to present their ideas and respond to questions. By providing this forum, the leadership of KMA is sending a clear message to the officials, politicians, and the public that we intend to have a voice in decisions made that affect our patients and our profession. In the past two years I have witnessed an Administration literally declare war on our profession. Being a political novice and living through that experience brought the message home to me that if you're going to play a role in politics you had better get in early. That is why we are here today. I sincerely hope that you find your candidate today *and* if you do I hope you get both personally and financially involved." *KMA*



## DEMOCRATS

### KMA QUESTIONNAIRE FOR GUBERNATORIAL CANDIDATES



**Paul Patton**



**John "Eck" Rose**

**What is your position on the provider tax?**

*I am absolutely convinced that this tax will reduce the number of high quality physicians practicing in Kentucky, and that it will adversely effect quality of health care for all Kentuckians.*

*The provider tax is unfair. The tax on some providers is assessed against overhead, others against income, and is not assessed at all on some. I support repeal or phasing out the tax as feasible without decimating the Medicaid program.*

**What is your position on the physician component of the provider tax?**

*That's a price too high to pay. We will eliminate the provider tax on physicians. I alone called for repeal of the provider tax on physicians last December. If we are to attract the smartest and hardest working people into medicine, we must develop a system which rewards them according to their contributions to society.*

*The tax on non-institutional providers is particularly troublesome. Nothing in the taxing structure takes into account the overhead cost variances of physician practices, and I support the repeal of the physician component of the provider tax.*

**Will you endorse and support repeal of the physician component of the provider tax during the 1996 regular session of the General Assembly?**

*While many other states have a provider tax, only Kentucky and West Virginia have a 2% provider tax on physicians' gross revenue. I am willing to take the short-term heat in order to do what is in the best long-term interest of the people of Kentucky.*

*Repeal of the physician component of the provider tax is a near inevitability. The critical question is how funds will be replaced. While reduction in funds derived by the physician component can be managed, repeal of the entire tax will necessitate a 30% reduction in Medicaid expenditures. It is not in the best interest of physicians to have the tax repealed if funds are replaced with cuts in physician reimbursements. I am the only candidate discussing legitimate replacement funds.*

**Do you plan substantial changes in the operation of the Cabinet for Human Resources and Medicaid?**

*We will make major changes in the operation of the Cabinet for Human Resources. I will appoint Steve Henry, MD, as an interim Secretary of the Cabinet for Human Resources to bring a physician's viewpoint to that major operation of Kentucky state government.*

*Until we have a more concrete idea of changes transpiring at the federal level, it would be disruptive and counterproductive to dramatically alter the Cabinet early in my administration. This does not mean that program and services changes and improvements cannot or will not be done.*

## REPUBLICANS



**Larry Forgy**



**Bob Gable**

### GUBERNATORIAL CANDIDATE RESUMÉS

*Generally speaking, the provider tax is inequitable and unfair and should be reconsidered in any general tax reform.*

*It should be abolished.*

#### **Larry Forgy**

Native of Logan County; BA & LLB George Washington University; Former Legal Counsel and Budget Director — Commonwealth of Kentucky; former VP and Treasurer — University of Kentucky; Employed — Frost & Jacobs, Lexington; Married, two children.

*I favor the repeal of the provider tax on physicians and other non-institutional providers.*

*It should be abolished as soon as possible, even by Special Session. Revenue might be replaced, for example, by repealing the income tax exemptions on pensions, or in other ways which may be recommended by the tax study commission.*

#### **Robert Gable**

Native of New York; BS Industrial Engineering Stanford University; Former Director Kentucky State Parks System; Former Chairman Republican State Party; Employed — Chairman, Stearns Enterprises, Lexington; Married, three children.

*I will propose significant reductions in the first biennial budget and complete elimination of the tax in my second budget, if not already accomplished.*

*Yes.*

#### **Paul Patton**

Native of Fallsburg, KY; BS Engineering University of Kentucky; Former Pike County Judge Executive — two terms; Former Owner and Operator Coal Company; Employed — Lt. Governor Commonwealth of Kentucky; Married, two children.

*The entire structure and operation of CHR will be on the table for consideration. Some major changes probably need to be made.*

*I would want a different Cabinet Secretary and a different and separate Commission for Medicaid. One person cannot concentrate enough on such demanding positions to do a proper job in both at once.*

#### **John "Eck" Rose**

Native of Clark County; BS mathematics Eastern Kentucky University; Kentucky Senator Since 1978; President of Kentucky Senate; Employed — Self Employed Farmer and Auctioneer; Married, three children.



## DEMOCRATS

	Paul Patton	John "Eck" Rose
<b>What is your position on privatizing Medicaid?</b>	<i>I believe we can save major money without reducing services by same sort of privatization of Medicaid. I don't say that insurance companies are necessarily the way to go but same kind of privatization will definitely be better than what we have. We need the provider community's input into the solution of this problem and Steve Henry and I will seek that input.</i>	<i>Medicaid is far more privatized than most agencies. Billing and claims is handled by private firms and services rendered by private providers. I do not support privatization of administration, eligibility determination, and insurance functions of the program. This concept could force private practice physicians out of business, requiring them in essence to work for Humana, Blue Cross, or Columbia/HCA if their practices are to remain viable. The fee-for-service provision of services should remain a viable option for both physicians and patients, and further privatization of Medicaid is a threat to the traditional practice of medicine.</i>
<b>What is your position on the recent dramatic physician reimbursement reduction in Medicaid?</b>	<i>Physicians must be fairly reimbursed for their services. We need the help of physicians to reduce fraud, abuse, overuse, and improper use of the Medicaid program.</i>	<i>The cuts were inappropriate, unnecessary, and hurt the entire process of health care reform. Legislative intent was not to authorize across-the-board cuts. The decision to cut reimbursement rates appears to have been made without regard to the budget surpluses that seem to have materialized since passage of the budget.</i>
<b>Most major health insurance plans employ a physician medical director to oversee the medical component of plans. Would you consider employing such a professional to consult with the Secretary, CHR, on needed policies?</b>	<i>Medical decisions must be made by physicians. A state bureaucracy cannot practice medicine without the direct involvement of a physician.</i>	<i>Yes, I would certainly consider this proposal and look for input from the medical community.</i>
<b>CHR is an enormous bureaucracy. Have you given any thought to separating Medicaid from CHR and establishing a separate Cabinet for Health Services?</b>	<i>CHR is 40% of state government. As such, it will receive an appropriate portion of my personal attention. I understand that CHR is too large for any one individual to oversee. I plan to split it into two cabinets, one for families and children, the other for health services.</i>	<i>I do not believe the answer to managing an enormous bureaucracy is to create another bureaucracy. Medicaid is an integral part of the CHR. Given the likelihood of increased federal funding in the form of block grants, I believe that keeping CHR whole is more appropriate.</i>

## REPUBLICANS

### Larry Forgry

### Bob Gable

*"Privatizing" Medicaid is simply a political play on words. In the strictest sense, privatizing would mean abolishing Medicaid as a government program with private enterprise assuming the responsibility. This is simply not feasible with a federally sponsored program of this type. We do plan to "mainstream" the Medicaid population in traditional health insurance coverage at significant savings and down-sizing of government.*

*My present view is that a BIG HMO or Preferred Provider would have to take profit off the top, risking too little left for the people who need the services. With continued alertness to fraud prevention, I sense that we are not terribly inefficient now.*

*I believe it to have been shortsighted and unnecessary. Sufficient surpluses were available to continue adequate payment for physician services. The long term result may be loss of access for low income people. "Mainstreaming" the Medicaid population through health-insuring organizations will resolve the reimbursement question to some extent since it will be subject to marketplace forces.*

*I have the impression that this is an economic, not health-care decision. Either way, it was an over-reaction, and unwise.*

*I would have no particular objections to having a medical director to oversee the medical component in the Medicaid program.*

*I would want the Department to continue employing outside consultants in specialty areas, but would definitely consider adding an in-house medical director if the Commissioner so recommended.*

*Serious consideration will be given to establishing a separate entity for Medicaid and possibly other health programs. At minimum, responsibility for various aspects of Medicaid administration and policy will be consolidated under a single office. Responsibility is currently dispersed throughout CHR.*

*Yes, but I have not concluded that it should definitely be done. If we conclude that the state agency should continue to run the Medicaid system (not privatizing the services), it appears that the other Departments have a useful interface within the Cabinet.*

### DOES **MAY 23** MEAN SOMETHING TO YOU?

The Kentucky Educational Medical Political Action Committee (KEMPAC) would like to remind you that Tuesday, May 23, is **Election Day** for the Primaries, and remember:

GET OUT THERE AND VOTE!

You **CAN** make a difference with your vote



## DEMOCRATS

	Paul Patton	John "Eck" Rose
<b>Physicians and their patients have a number of concerns with House Bill 250. What is your general perception of the legislation and its performance to date?</b>	<i>The insurance reform portions of HB 250 are not fully implemented and my position is to see how this portion works and be willing to take a second look as problems develop.</i>	<i>The legislation is a landmark in health reform, and if given the chance will ameliorate the need for more radical change. This is of critical importance to physicians, who have the most to lose should market-based reforms fail. The reforms eliminate preexisting conditions, prohibits companies from dropping persons because they get sick, and helps individuals and small businesses find affordable insurance. With the exception of repeal of the provider tax and the DOP, and possible changes proposed by the Health Policy Board, I will support implementation of HB 250.</i>
<b>Several legislators and groups have called for repeal of HB 250. Do you support repeal of all or part of HB 250? If so, of what portion do you disapprove?</b>	<i>I will look closely at HB 250 and its effect on health care delivery in Kentucky and be willing to correct those problems which surface.</i>	<i>Many people supporting repeal of HB 250 are representatives and supporters of the insurance industry who want to abolish provisions which will force insurers to make money from selling insurance rather than making money as they do now by denying insurance to high risk people. Several provisions of HB 250 are helpful to citizens, particularly insurance reform. I do not favor repeal of HB 250 but would look at all phases of the legislation. I support repeal of the DOP.</i>
<b>The KMA supports an amendment to Section 54 of the Kentucky Constitution that would permit the General Assembly to place a limitation on noneconomic awards. Would you support submission of this amendment to the voters of Kentucky for their ratification or rejection?</b>	<i>As with any proposition, I would need to look at the details of any proposed amendment to the Kentucky Constitution but I would tend to support an amendment which would reduce the need for defensive medicine, when no other need for treatment is indicated for medical purposes.</i>	<i>Governors play no role in enacting Constitutional Amendments as this is strictly a General Assembly function. I prefer to wait and see how the issue evolves in Congress and reserve judgment. However, I was a strong proponent and supporter of the 1988 tort reform enacted by the General Assembly and supported by the KMA.</i>

## REPUBLICANS

### Larry Forgy

### Bob Gable

We believe that the entire "Clinton-type experiment" on health care reform should be on the table for reconsideration, change or repeal.

*It is another of Frankfort's dictatorial enactments of the past few years, and as such is quite frightening. It seems likely to break a quality medical system which was not "broke." The one most positive aspect seems to be the change for universal access to health insurance. But we do not yet know how that will work. Will costs jump up so much as to make Kentucky employers noncompetitive in yet another way? If so, we will need the backbone to undo the damage, and quickly. I do rejoice that many physicians are screaming bloody murder about the authoritarian commandments emanating from Frankfort. They are hollering about FREEDOM, and I only wish more Kentuckians were doing the same — on a whole variety of matters.*

We have particular reservations concerning;  
a. The Health Policy Board would seem to preempt the governor and executive branch as the focal point of health care policy and initiatives.  
b. Restriction of health insurance offerings to four or five state approved plans. We believe this represents unnecessary government intrusion on free enterprise and individual choice. It would seem to represent flawed logic in that the same objective of comparability for cost comparison could be achieved by requiring three or four standard plans, but not limiting other choice.  
c. The Purchasing Alliance, an experiment which simply invokes another broker in the system and may increase the cost of public employees' benefits.  
d. The Discount Option Program which was ill-conceived and has grossly missed the objectives of extending care to the uninsured.

*We probably need to remove some of the powers, maybe a lot of powers from the Health Policy Board. I dislike mandates. The provisions assuring access to insurance may or may not work without driving employer costs through the roof. If these become uncompetitive, we may have to go back to doing cost-transfers in something like the earlier ways.*

I reserve judgment on this point pending federal action. However, your membership should know I am not a "plaintiffs" lawyer and have over time devoted my law practice to commercial matters.

*My proposal has been to require that 100% of punitive damages be paid to the State Treasurer, without deduction of any legal fees or other cuts. My approach might require a constitutional amendment too; if so, I would be glad to support KMA's if it has a better chance for passage. However, if mine does not require Constitutional action, I would rather try it that way.*

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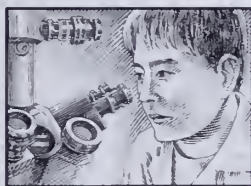


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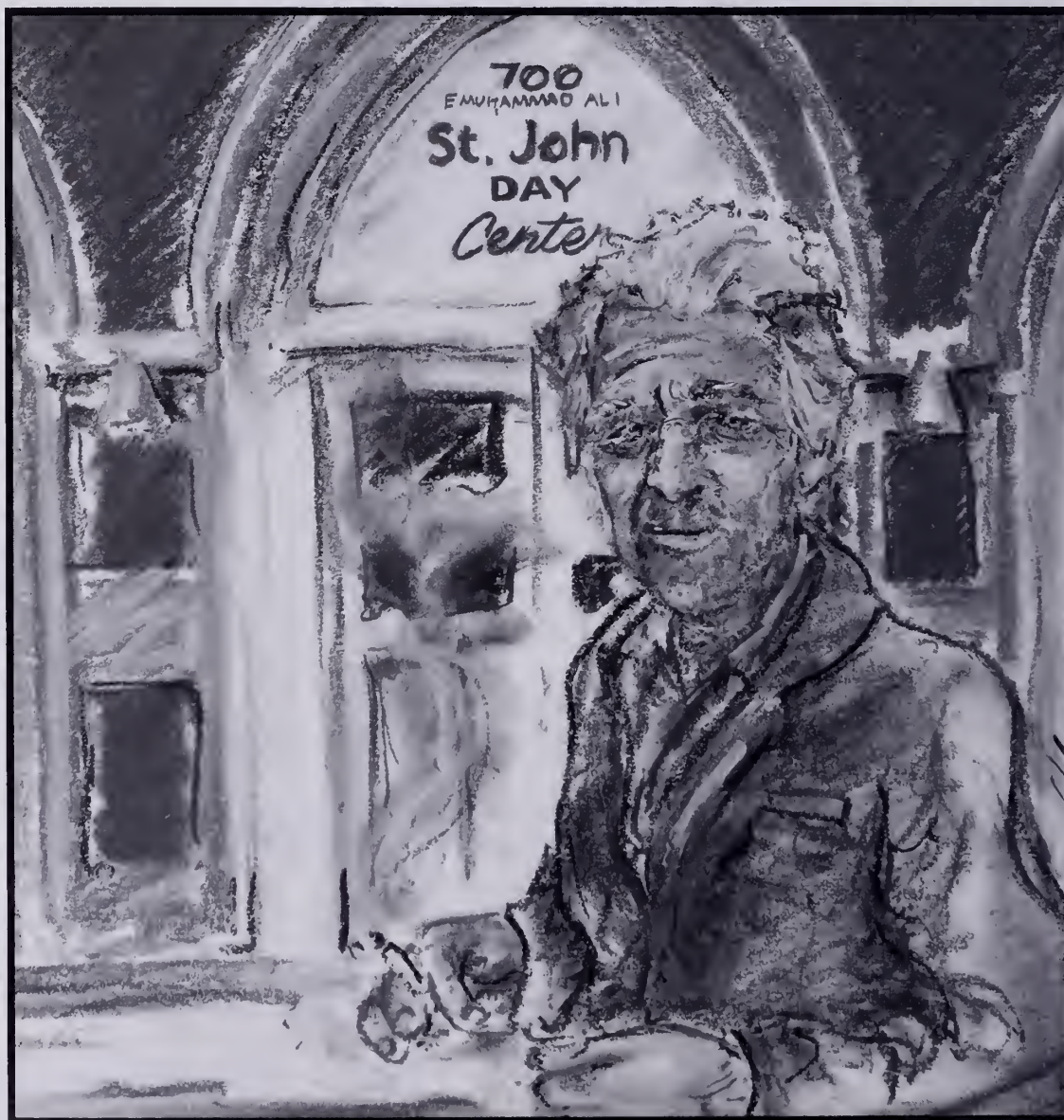
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# Quality of Life and Functional Status Among Homeless Men Attending a Day Shelter in Louisville, Kentucky

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Lisa R. Hall, BS; Kristi M. Wright, BS*



The homeless present important social and medical problems in most parts of the United States, including urban areas of Kentucky. While some studies have examined the health status of the homeless, very little is known about their quality of life or functional status. In the present study, 188 homeless men attending St. John's Day Shelter in Louisville completed an interviewer-assisted instrument that assessed self-perceived quality of life using the Perceived Quality of Life (PQOL) scale and self-perceived functional status using the Dartmouth COOP charts. The instrument also included questions on demographics and health risk behaviors of the homeless men. The results show that the typical homeless male attending St. John's is an unmarried, white, middle-aged high school graduate who is unemployed. In terms of quality of life, these men indicate general satisfaction with their physical and cognitive abilities, but significantly lower satisfaction with the social aspects of their lives. With regard to functional status, the homeless men report that they function best in terms of physical fitness and ability to perform daily activities. They report lower assessments of overall health, feelings, quality of life, and social support. These results suggest that poor social role functioning among homeless men is a major contributor to their poor quality of life. Thus, improving their health and quality of life may require an emphasis on social services in addition to routine medical care.

Homelessness is a growing social concern in most parts of the United States. It has been estimated that about 1% of the national population is homeless, with a prevalence of nearly three million people.<sup>1,2,3</sup> In Jefferson County, Kentucky, 14,833 homeless individuals, mostly single males, attended crisis, transitional, or homeless shelters during 1991. The number of single homeless men in Jefferson County increased 39% between 1990 and 1991,<sup>4</sup> compared to a national annual rate of increase for the homeless of 10% to 20%.<sup>5</sup>

Medical problems of the homeless are similar to those of patients attending primary care clinics,<sup>3,6,7</sup> although the prevalence of some conditions may be higher among the homeless, including chronic obstructive lung disease, dermatitis, painful feet, vision disturbances, dental problems, injuries, and substance abuse.<sup>3,6,7,8,9</sup> Mental health issues among the homeless are also a source of concern; the age-specific prevalence

of mental disorders among homeless men is about twice that of males living in households, and the utilization rate for psychiatric service among the homeless is twice that of a domiciled comparison group.<sup>10</sup> The most frequently reported psychiatric conditions among the homeless are substance abuse, anxiety, and antisocial personality disorders.<sup>10,11</sup>

In terms of self-perceived health status, several studies have reported that 30% to 45% of homeless adults rate their health as "fair" or "poor."<sup>5,7,12,13</sup> This is a higher proportion than that found in a sample of domiciled adults in a similar age group.<sup>14</sup> Very little is known, however, about the self-perceived quality of life and functional status of the homeless. In fact, the authors know of no published report of a self-assessment of either quality of life or functional status by a homeless population. The study described in this article was designed to address this information gap by assessing the quality of life and functional status of a sample of homeless men attending St. John's Day Shelter, which is located in urban Louisville, Kentucky. Quality of Life was measured by the Perceived Quality of Life (PQOL) scale,<sup>15</sup> and functional status was measured by the Dartmouth COOP charts.<sup>16</sup> (The name "COOP" comes from the fact that the charts were developed by the Dartmouth COOP Project, a network of community practices that COOPerate on research activities.<sup>17</sup>) We also collected information on the demographics, health risk behaviors, and personal resources of this group.

## Methods

St. John's Day Shelter offers a variety of services for the personal, medical, and dental needs of homeless men over the age of 18, although there are no on-site eating or sleeping facilities. An average of 230 men used the shelter each day during the study period. Homeless men were defined in this study to be those males aged 18 or older who stated that they were living in missions or shelters, in the outdoors, in vehicles or other sites not designed for shelter, at the home of relatives or friends, or in single room occupancies (such as hotels, motels, rooming houses, etc), with an understanding that they did not have a permanent house or apartment to which they could go.<sup>18</sup> This definition is similar to the definition of "homeless" given in the McKinney Act.<sup>19</sup>

Because of difficulties in enumerating and interviewing the homeless, they have been char-

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## Homeless Men Attending a Day Shelter

acterized as "difficult-to-sample."<sup>20</sup> In the present study, there was no adequate sampling frame from which to choose a random sample and systematic sampling proved to be infeasible because of the heavy volume at the check-in desk. Thus, the "intercept" method of sampling<sup>21</sup> was used, whereby potential participants were approached and queried as to their willingness to participate. As part of their training in using this method, the interviewers were instructed to approach attendees without regard to age, race, or other visible demographic characteristic in order to insure representativeness of the sample. Only incoherent, intoxicated, or grossly belligerent men were excluded from consideration.

Homeless men who attended St. John's between June 24 and July 17, 1992, were approached by the study team. Written informed consent, approved by the University of Louisville Human Studies Committee, was obtained from each participant. Two trained interviewers (LRH and KMW) conducted the interviews in private rooms. The average time to complete an interview was approximately 20 minutes.

The interview instrument consisted of 61 items, which included questions taken from other standardized instruments. Questions concerning demographics and health risk behaviors were abstracted from the Carter Center Health Risk Appraisal;<sup>22</sup> the alcoholism screening questions recommended by Rakel<sup>23</sup> were also included. These questions were: "Have you ever had a health, legal, or personal problem as a result of drinking alcohol?" and "When was your last drink?" If the subject answered "yes" to the first question or their answer to the second question was as recent as 24 hours ago, the subject was positive for alcohol abuse.<sup>24</sup>

For this study, quality of life was defined in terms of a global assessment of positive indicators of subjective well-being.<sup>25, 26, 27</sup> Thus, the Perceived Quality of Life (PQOL) scale,<sup>15</sup> which measures multiple dimensions of life satisfaction, was included in the interview instrument. For example, one of the questions on the PQOL dealing with the physical dimension is "How satisfied are you with your physical health (the health of your body)?" Prior to reading the questions, the interviewer presented the respondent with a printed scale ranging from 0 to 10, with 0 corresponding to "very dissatisfied" and 10 corresponding to "very satisfied." The interviewer then asked the respondent to pick a number between 0 and 10 (inclusive) after reading each of the 19 questions

on the PQOL.

The PQOL has four subscales which measure the following dimensions of life satisfaction: physical health (4 items), cognitive health (2 items), social health (12 items), and food (1 item). It has been used to measure self-perceived quality of life of patients who had been treated in intensive care<sup>15, 28</sup> and elderly Medicare beneficiaries.<sup>29</sup>

The Dartmouth COOP Charts<sup>16</sup> were also included in the interview instrument. These charts assess functional status in the physical, emotional, and social domains. For example, one of the questions on the COOP is "During the past 4 weeks, what was the most strenuous level of physical activity you could do for at least 2 minutes?" As the interviewer read the question to the respondent, she presented him with a chart containing the question and "stick figures" that illustrate the five possible answers: (1) very heavy, (2) heavy, (3) moderate, (4) light, or (5) very light. The respondent was then asked to pick the answer that best described himself. This process was repeated for each of the nine COOP questions, with each response being a number between one and five, inclusive. Higher scores indicated poorer levels of functioning. The COOP charts have been used to measure functional status among male veterans being treated for chronic medical conditions, male and female adults with acute and chronic diseases, and male and female diabetics.<sup>30</sup>

### Statistical Analysis

The Mann-Whitney-Wilcoxon test<sup>31</sup> was used to compare the age distributions (in 10-year intervals) of the respondents and non-respondents. Fisher's Exact Test<sup>32</sup> was used to compare the percentage of ethnic minorities among the respondents and non-respondents. The chi-square test<sup>31</sup> was used to compare the age distribution of our sample with that of the target population (all homeless men who attended the shelter during the study period). The exact binomial test<sup>31</sup> was used to compare the percentage of ethnic minorities in our sample with that of the target population. One-group repeated measures analysis of variance<sup>33</sup> was used to test for significant differences among the means of the PQOL subscales and among the means of the individual COOP items. The unequal variance t-test<sup>34</sup> was used to compare the mean COOP scores obtained in this study with those provided in a previously published report for another population.<sup>30</sup>

**Table 1.** Demographic Characteristics of Homeless Men Attending St. John's Day Shelter (n = 188 except where otherwise noted)

Characteristic	Percent	Characteristic	Percent
Ethnicity		Military Veteran	39.5
White	78.7	Religious preference	
Black	18.6	Baptist	41.0
Hispanic	1.1	Catholic	14.9
Native American	0.5	Other Christian	34.6
Other	1.1	Non-Christian	2.7
Marital Status		None	6.9
Single	44.7	Political Party Preference (n = 183)	
Married	1.1	Democrat	40.9
Divorced	38.8	Republican	11.5
Separated	13.3	Independent	9.3
Widowed	2.1	None	38.3
Education		Reason for homelessness (n = 185)	
Grade school only	12.8	Inadequate income	33.5
Some high school	22.9	Family problems	29.2
High school grad or GED	37.2	Substance abuse	15.1
Some college	21.3	Transient	14.1
Technical school graduate	2.1	Other	8.1
College graduate	2.7	How long homeless	
Post-graduate degree	1.1	Less than 1 year	34.5
Usual occupation		1-5 years	32.4
Laborer	68.1	More than 5 years	33.0
Service professions	9.6	Louisville is hometown	25.5
Technical/sales	5.3		
Other	17.0		
Characteristic	Mean $\pm$ SD (Range)		
Age (years)	40.6 $\pm$ 11.3 (19-75)		

## Results

During the interview period, 339 different men attended St. John's Day Shelter and 202 (60%) of them were asked to participate in the research by the study team. Among those solicited, 188 (93%) successfully completed the interview, 11 (5.2%) terminated the interview, and 3 (1.8%) refused to participate. Information on age and race was obtained from the 14 men who did not complete the interview. No significant differences were found between the respondents and non-respondents in terms of age (Mann-Whitney-Wilcoxon test:  $P = 0.383$ ), or race (Fisher's exact test:  $P = 0.068$ ). The sample of 188 was representative of the 339 who attended during the study period with respect to age, and approximately so for race. The age distribution of the sample (in 10-year intervals) did not differ significantly from that of the target population (chi-square test:  $\chi^2 = 8.50$ , d.f. = 7,  $P = 0.291$ ). There was a slight underrepresentation of ethnic minorities in the sample compared to the target group: 21.3% of the sample were nonwhite, whereas 31.2% of all those at-

tending during the study period were nonwhite (exact binomial test:  $P = 0.003$ ). However, post-stratification weighting of PQOL and COOP scores to adjust for the underrepresentation of ethnic minorities yielded estimates that were not meaningfully or statistically different from the raw estimates for any item on either scale. Thus, all information reported below is based on the unadjusted sample data.

The demographic characteristics of the men in our sample are summarized in Table 1. The typical homeless male in our study population is a middle-aged, white, unmarried, unemployed, high school graduate with previous work experience as a laborer who does not consider Louisville to be his hometown. His religious preference is a Christian religion other than Catholic and his political party preference, if he has one, is Democratic.

Our sample respondents were also asked about their personal resources. Food stamps provide the only source of government aid for 30.9% of the sample and 49.5% do not receive any type of government aid. The majority (57.4%) claim to



## Homeless Men Attending a Day Shelter

**Table 2.** Summary of PQOL Scores for Homeless Men Attending St. John's Day Shelter (n = 188)

PQOL Subscale or Item <sup>a</sup>	Mean (N = 188)	SD
AVERAGE OF ALL ITEMS	5.7	1.7
COGNITIVE HEALTH SUBSCALE	7.3	2.3
Conversational skills	7.4	2.5
Thinking and remembering	7.2	2.8
PHYSICAL HEALTH SUBSCALE	7.1	2.1
Caring for yourself	8.0	2.5
Getting outside	7.3	3.0
Amount of walking	6.6	3.8
Physical health	6.5	3.3
FOOD SUBSCALE	7.0	2.8
SOCIAL HEALTH SUBSCALE	4.9	2.0
Respect from others	6.8	3.0
How happy you are	5.8	3.1
Meaning and purpose of your life	5.6	3.4
Amount of variety in your life	5.6	3.3
Recreation or leisure	5.4	3.6
Help from family and friends	5.1	3.9
Help given to family and friends	5.1	3.6
Seeing family and friends	4.9	3.5
Contribution to community	4.7	3.7
Sexual activity	4.7	3.8
How your income meets your needs	2.5	3.4
Retirement or current job	2.4	3.4

<sup>a</sup> Scores range from 0 to 10: 0 indicates Very Dissatisfied and 10 indicates Very Satisfied.

sleep in missions and shelters, while 11.2% sleep outside (in parks, along streets, on river banks, etc). Almost all (84.6%) say that they eat most of their meals at a mission. Over half (52.0%) of the respondents have children; the mean number among the parent group is 2.4 (SD = 1.7).

Although 64.9% of the sample say they receive health care at some type of clinic, 17.6% report that they do not receive any health care. Nearly a third (30.2%) report that they have been treated for mental, nervous, or psychiatric problems during their lifetime. Prescription medication is taken daily by 26.5% of the sample, mostly for neuropsychiatric problems.

The interview instrument also contained questions concerning health risk behaviors. Tobacco is used in some form by 89.9% of the respondents and 57.6% exhibit possible alcoholism according to the screening questions. Approximately one out of four (26.8%) in our sample say they have been imprisoned at some time. Almost half (49.5%) observed or experienced violence or abuse while growing up. Most of the sample population (77.7%) feel lonely at least some of the time. Almost all of the homeless men say that their spiritual life is either very important (53.2%) or somewhat important (37.8%) to them.

As seen in Table 2, the results of the individual PQOL items show that the homeless in our sample are most satisfied with their ability to care for themselves, their conversational skills, the amount of time they spend outside, and their ability to think and remember. They are least satisfied with their current job and income. The results for the PQOL subscales show that the men in our sample have similar levels of satisfaction in the domains of cognitive health, physical health, and food; none of the differences among these means are statistically significant ( $P \geq 0.286$  for each pairwise comparison). The men indicate least satisfaction on the social health subscale; this mean is significantly different from that of each of the other PQOL subscales ( $P \leq 0.0001$  for each comparison). The average PQOL score for all items indicates only a moderate degree of satisfaction.

The results of the COOP for our sample are given in Table 3. The COOP items indicating best functional status (lowest scores) are ability to perform daily activities and physical fitness; both of these means are significantly different from the means of all other COOP items [ $P \leq 0.003$  for each pairwise comparison except physical fitness vs social activities ( $P = 0.042$ )]. Poorest functional status (highest scores) was reported for overall

**Table 3.** Comparisons of COOP Chart Scores for Homeless Men With Those for Domiciled Veterans<sup>a</sup>

COOP Chart <sup>a</sup>	SJDS <sup>b</sup>		Mean	VA <sup>c</sup>		p-value <sup>d</sup>
	Mean (n = 188)	SD		Mean (n = 231)	SD	
Daily activities	2.1	1.2	2.4	1.3		.008
Physical fitness	2.1	1.4	2.5	1.3		.002
Social activities	2.3	1.4	1.9	1.2		.001
Pain	2.5	1.5	1.5	1.0		<.001
Change in health	2.8	1.1	2.9	0.8		.239
Social support	2.9	1.6	1.6	1.2		<.001
Quality of life	3.0	1.1	2.0	1.0		.001
Feelings	3.0	1.3	2.1	1.0		<.001
Overall health	3.1	1.3	3.2	0.9		.179

<sup>a</sup> Chart scores range from 1 to 5: 5 indicates poorest status and 1 indicates best.

<sup>b</sup> St. John's Day Shelter, Louisville, KY.

<sup>c</sup> Veterans Administration outpatient clinic in a rural area.<sup>30</sup>

<sup>d</sup> Result of two-tailed unequal variance t-test vs. St. John's Day Shelter.

<sup>e</sup> This chart was not used in this study.

health, feelings, quality of life, degree of social support, and change in health over the last 4 weeks; these means are significantly different from the means of all other COOP items ( $P \leq 0.007$  for all pairwise comparisons).

Table 3 also contains the results of a comparison of the mean COOP scores for our sample with those from a domiciled sample of 231 lower-income male veterans that were predominantly white, older than 65, and under care for chronic health problems at a rural Veterans Administration hospital.<sup>30</sup> The homeless are found to be significantly better in self-reported physical fitness and ability to perform daily activities, but significantly worse in pain, feelings, social support, and social activities ( $P \leq 0.008$  for all comparisons). There was no significant difference between the homeless and the domiciled veterans in either change in health over the last 4 weeks or overall health ( $P \geq 0.179$  for both comparisons).

## Discussion

The socio-demographic characteristics of our sample are consistent with previous descriptions of the homeless.<sup>1,10,12,35</sup> As in other reports,<sup>36</sup> a large proportion (39.5%) of the sample are veterans. The prevalence of self-reported mental health problems among our participants (30.2%) is slightly lower than in other reports.<sup>37</sup> Almost 65% of the homeless in our sample say that they receive health care from clinics. This is probably an overestimate as compared to other homeless populations, due to the presence of an on-site clinic at St. John's Shelter. There is evidence that the homeless who do not use day shelters have a lower degree of health service utilization when compared to those who attend shelters.<sup>6,14</sup>

Substance abuse is common among our sample of homeless men, with nearly 90% using tobacco and almost 60% reporting possible alcoholism. Other reports suggest a smaller percentage of tobacco users among the homeless.<sup>6</sup> One possible explanation for the higher prevalence in this study is that Kentucky has one of the highest tobacco-smoking rates in the nation, attributable in part to lower state taxation on tobacco and lower cost of cigarettes.<sup>38</sup> The test characteristics of the two alcoholism screening questions used in our questionnaire battery are excellent: a reported sensitivity of 91.5% and specificity of 89.7% in high risk populations.<sup>24</sup> Nevertheless, the reported prevalence of alcoholism among our respondents may be an underestimate due to denial or social

acquiescence bias. Only 15% of our sample attributed their homelessness to substance abuse; however, it is likely that some of those who claimed unemployment or family problems as their reason for becoming homeless actually became so as a direct result of such abuse.

As indicated by the PQOL and COOP scores, the homeless in our sample perceive themselves to be physically fit, perhaps as a result of the demands of the homeless lifestyle, with many long walks from sleeping quarters to soup kitchen to day shelter. Despite the high prevalence of self-reported psychiatric illness, most of them consider themselves to be capable of coherent thinking and conversation.

The main detractor from the quality of life of these homeless men appears to be related to poor social role performance, perhaps compounded by poor emotional status and lack of social support. This finding is reinforced if one deletes the two items on the Social Health subscale of the PQOL which indicated least satisfaction (current income and current job) and then compares the mean score on the average of the remaining items with the mean scores on the Physical and Cognitive Health subscales; the *p*-value is still less than 0.0001 for both comparisons. In addition, the homeless men in our sample were found to be significantly worse than a sample of older domiciled veterans with chronic health problems in terms of the COOP items related to social activities and social support.

This self-perceived deficiency in the social aspect of health lends support to the social alienation model<sup>5,10,39</sup> for homelessness. The homeless are known to have poor social networks, with about one third reporting no relatives, nearly half reporting no friendships, and more than two thirds reporting no confidant in one epidemiologic study.<sup>10</sup> In addition, the homeless socialize less often than their domiciled counterparts.<sup>7</sup> The high prevalence of loneliness among our study participants provides further support for this model, although comparison data are not available. Other studies have focused on what the homeless feel they need to improve their lives. The most common responses typically deal with the social aspect of their lives; in particular, the three most important things the homeless say they need to have a better life are (in order of importance): improved social relations, employment, and housing.<sup>35</sup>

One might argue that the sampling method used in this study could yield biased results.



## Homeless Men Attending a Day Shelter

While it is true that the "intercept" method can yield a sample that is not representative of the target population, the interviewers in the present study were trained to approach potential subjects without regard to race, age, or other discernible characteristic, thereby reducing the magnitude of selection bias. Despite this, however, ethnic minorities were under-represented in the sample when compared to all those who attended the shelter during the study period. One possible explanation for this under-representation is the fact that both interviewers were white, which could have resulted in a reluctance among the ethnic minorities to participate in the interview.<sup>40</sup>

Another potential source of selection bias lies in the fact that homeless men attending day shelters are not necessarily representative of homeless men in general. Sample participants were already within the supportive environment of a shelter and thus may be healthier, more functional, and more socially skilled than those who live outside. On the other hand, since St. John's provides both medical and dental services, the sampled population may have more clinical problems that negatively impact on functional status, health perceptions, and quality of life assessments. The generalizability of the results of this study to other homeless populations is also suspect; however, the characteristics of the sample respondents were generally comparable to those reported in published studies of other homeless populations.

Another potential source of bias is the lack of verification of demographic and health risk information due to financial constraints. The reliability and validity of the interview instrument are also a concern. Convergent validity of the PQOL for this sample is supported by the lack of satisfaction with income and employment indicated by the PQOL in a group known to have high unemployment and few external resources. In addition, the interviewers recorded their assessment of the validity of each participant's responses at the end of the interview and each interviewer judged the responses of the 188 subjects who completed the interview to be valid self-reports. The reliability of the COOP and PQOL in this study was examined using stratified analysis. Cronbach's alpha<sup>41</sup> was calculated after stratifying on covariates possibly related to cognitive impairment, including neuropsychiatric history, positive screening for alcoholism, duration of homelessness, time and day of interview, etc. In all cases, Cronbach's alpha was in the generally

acceptable range of 0.80 or greater.<sup>42</sup> No significant differences among strata were observed.

In spite of the limitations of this study, we have helped to fill an information gap concerning the self-perceived quality of life and functional status among homeless men. As with any group of patients, this type of information can be very useful in caring for the homeless and it can also provide valuable insight to those responsible for developing public policy and designing relief programs for the homeless.

Our results suggest that poor social role functioning among homeless men is a major contributor to their poor quality of life. The findings of deficiencies among the homeless in the basic requirements for social role performance as individuals and family and community members are consistent with existing models of health and subjective well-being.<sup>43</sup> Furthermore, subjective well-being is primarily determined by social role functioning and is only marginally related to objective physical conditions.<sup>44</sup> Hence, improving the health and quality of life of homeless men may require an emphasis on social services as well as routine medical care. In particular, coordinated services directed specifically at social role functioning would address both the social health and social support concerns expressed by the homeless in this study.

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# Pathophysiology and Management of Noncardiac Chest Pain

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*Noncardiac chest pain is a common but important clinical challenge with respect to diagnostic strategy as well as therapeutic intervention. The most common esophageal disorder associated with chest pain syndrome is gastroesophageal reflux; 24-hour ambulatory monitoring of esophageal pH and the determination of the symptom index are useful in patient evaluation. A high frequency of abnormal esophageal motility has been reported in noncardiac chest pain, but its clinical significance remains controversial. Patients with chest pain and normal coronary angiogram may have microvascular angina. Musculoskeletal conditions account for at least 10% of the cases of noncardiac chest pain. The potential effects of stress and altered psychological states in this phenomenon must be considered. The role of panic attacks in the production of pain needs to be clarified. Investigations to elucidate the exact cause of chest pain as well as its treatment should be individualized to the patient.*

Recurrent chest pain causes anxiety for patients as well as the physicians because of the fear of life-threatening cardiac disease. The evaluation and management of such patients is a common but important clinical challenge to the primary care physician, cardiologist, and the gastroenterologist alike. This syndrome is not a recent entity; physicians have been confronted by these patients for decades. In 1860, the term *soldier's heart* was used to describe British soldiers who presented with chest pain during the war.<sup>1</sup> In 1892, Sir William Osler described oesophagismus or spasm of esophagus and commented, "this spastic stricture of gullet is met with in hysterical patients or hypochondriacs."<sup>2</sup> In this article we will discuss the prevalence and potential etiologies of noncardiac chest pain. Diagnostic approach will be suggested and treatment options reviewed. Recent research findings that have enabled us to enhance our diagnostic and

therapeutic approach to this clinical problem will also be discussed.

## Case 1 —

CR is a 42-year-old white female with a prior history of bronchial asthma who complained of retrosternal chest pain continuously for a period of one-and-a-half years. There was occasional nausea but no vomiting. Her appetite was good and she had not lost weight. She did not smoke cigarettes or drink alcohol. She was treated for asthma with theophylline and several inhalants. Physical examination revealed her to be an obese white female with normal vital signs. Lung and abdominal examination was normal. Cardiac evaluation was unremarkable. Endoscopy showed no gross evidence of inflammation or obstruction in the upper gastrointestinal tract. Esophageal manometry revealed marked increase in amplitude and duration of contractions in the distal esophagus consistent with nutcracker esophagus. A 24-hour pH monitoring study revealed markedly abnormal acid reflux in both the upright and supine positions. Her asthma and esophageal motility disorder were attributed to acid reflux. Theophylline was discontinued. She was treated with omeprazole 20 mg bid. There was resolution of her chest pain and asthmatic symptoms in about 3 weeks.

## Case 2 —

A 28-year-old WF presented with the complaint of intermittent epigastric and retrosternal chest pain. The pain was sharp in character, non-radiating and relieved with milk. She also complained of intermittent heartburn. There was no nausea, vomiting, palpitations, diaphoresis, dysphagia and odynophagia. Her appetite was good and she had not lost weight. Physical examination was unremarkable except for hoarseness of voice. The laryngeal examination was normal. Further questioning revealed she had been told by others about a voice change over the last couple of years. Complete blood counts, serum chemistries,

amylase and lipase as well as thyroid function tests were normal. A right upper quadrant ultrasound did not reveal any evidence of cholelithiasis. An upper endoscopy did not reveal any evidence of esophagitis. Results of the 24-hour pH monitoring showed markedly abnormal acid reflux in both upright and supine position. She was treated with omeprazole with resolution of her symptoms including improvement in her voice.

## Discussion

A conservative estimate suggests that there are about 200,000 new cases of noncardiac chest pain diagnosed each year in the United States.<sup>3</sup> This accounts for approximately 20% to 40% of the people undergoing cardiac catheterization for apparent angina pectoris. Although many questions remain to be answered, new information has improved our understanding of the mechanisms of chest pain in these patients and our ability to appropriately evaluate this condition.

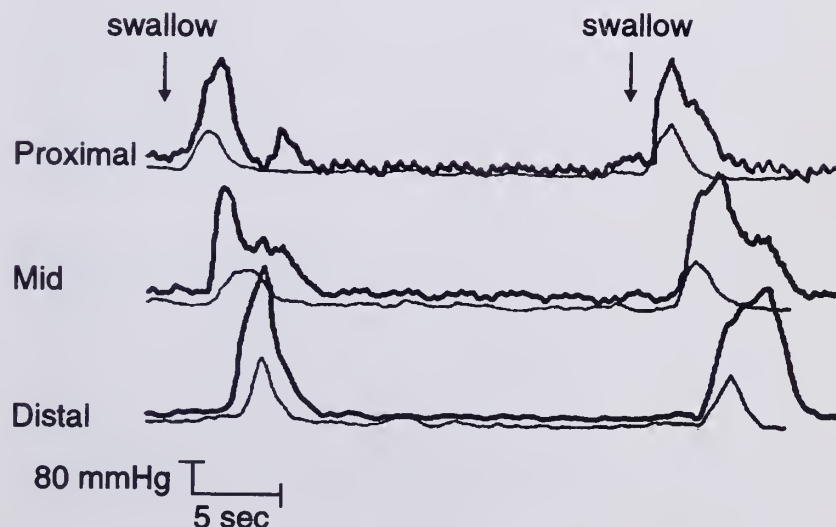
## Pathogenesis:

A variety of clinical syndromes have been suggested although a specific pathophysiology or mechanism of the pain production is unclear. The most common etiologies can be divided into cardiac, esophageal and other gastrointestinal disorders, musculoskeletal and psychiatric disorders. On the basis of recent findings, Beitman et al have suggested that microvascular angina, gastrointestinal disorders like reflux disease, and motility disorders and panic disorder each account for about 25% of the causes of the chest pain; miscellaneous disorders such as musculoskeletal disorders and mitral valve prolapse were implicated in the remainder.<sup>4</sup> Until recently, interest in these diseases was segregated by specialty fields but this may be inappropriate as these syndromes often overlap, adding to the complexity of the problem.<sup>5</sup> For example, esophageal motility disorders are found in 23% to 75% of patients with microvascular angina. One third of these patients also have panic attacks. On the other hand, 25% of the patients with an esophageal cause for their chest pain also have diagnostic criteria of panic disorder. Whether these relationships represent the coincidental occurrence of several common diseases or a common pathophysiologic mechanism is unknown. How these abnormalities interact has not yet been determined.

## Esophageal causes

Because the esophagus has a similar location and innervation as the heart, an esophageal source for unexplained chest syndromes has been frequently suggested.<sup>5</sup> Two types of problems are likely to produce chest pain: gastroesophageal reflux and esophageal motility disorders. Traditionally, esophageal dysmotility was considered to be the commonest etiology. Recent studies have emphasized the importance of gastroesophageal reflux disease as a more likely component of esophageal pain.<sup>6</sup> The specific mechanism or mechanisms by which pain might arise from the esophagus are unknown. Traditionally, esophageal chest pain is attributed to stimulation of chemoreceptors, mechanoreceptors, or thermoreceptors. Irritable esophagus is the emerging concept that implies a generalized alteration in esophageal pain threshold causing abnormal nociception.<sup>7</sup>

*Esophageal dysmotility:* Schmidt was the first to report a high frequency of abnormal esophageal motility findings in patients with unexplained chest pain.<sup>8</sup> Patients however could not distinguish the pain of ischemic heart disease from that of esophageal disorders.<sup>8</sup> In one large study of 910 patients, 28% who had esophageal manometry for chest pain were found to have abnormal esophageal motility.<sup>9</sup> The most frequent finding (48%) was the "nutcracker esophagus" (Fig 1). Tradi-



**Fig 1 — Normal esophageal motility tracing superimposed on recording of nutcracker esophagus. The amplitude and duration of contractions in nutcracker esophagus is much higher than normal.**



## Noncardiac Chest Pain

tionally, diffuse esophageal spasm was considered to be a potential cause of noncardiac chest pain although more recent studies suggest that it may be uncommon.<sup>9</sup> A small percentage of patients with noncardiac chest pain will demonstrate a hypertensive lower esophageal sphincter. Most patients with abnormal motility findings however fall into the category of nonspecific esophageal motility disorder.

The prevalence of esophageal manometric abnormalities is significantly higher in patients with angina-like pain and normal coronary angiogram than in patients with significant coronary artery disease.<sup>10</sup> However, it is rarely possible to show that the dysmotility itself is the cause of the pain. Most patients with esophageal dysmotility are asymptomatic at the time of diagnosis. Thus, the relationship between chest pain and abnormal esophageal motility is not necessarily cause and effect. It is speculated that the abnormal manometric findings may be a marker for more severe motility abnormalities occurring during the episodes of chest pain representing an epiphenomenon for chest pain.<sup>5</sup>

*Gastroesophageal reflux:* Studies have suggested a 50% incidence of gastroesophageal reflux disease (GERD) among patients with noncardiac chest pain.<sup>11</sup> GERD is more easily diagnosed and treated than most of the other causes of chest pain in patients with normal coronary arteries. However, exercise can induce episodes of reflux causing it to be confused with anginal pain.<sup>12</sup> Second, in some patients with coronary artery disease, esophageal acid perfusion and presumably gastroesophageal reflux results in elevation of the heart rate which can cause myocardial ischemia.<sup>13</sup> In addition, coronary artery disease and gastroesophageal reflux may coexist making it difficult to determine the origin of individual pain episodes.

When is the esophagus the cause for chest pain? It has been suggested that the esophagus is a probable cause if abnormal motility findings are present at baseline. Baseline esophageal manometric dysmotility has been found in 20% to 30% of cases with noncardiac chest pain. The esophagus is a definite cause if the substernal pain is produced during provocative testing and an esophageal abnormality is recorded during a spontaneous pain event.

### Cardiac Causes

Microvascular angina (syndrome X) is a disease

characterized by normal epicardial arteries in which there are abnormalities of small vessel coronary vasodilatory reserve identified during atrial pacing after ergonovine.<sup>14</sup> Patients with microvascular angina have chest pain under stress because their coronary artery microcirculation fails to adequately dilate and supply sufficient blood to the myocardium. In addition, esophageal motility abnormality, heightened cardiac nociception, and panic disorders have been observed in a sizable proportion of patients with microvascular angina.<sup>15,16</sup> Studies by Cannon et al suggest a generalized abnormality of vascular smooth muscle function.<sup>15</sup> The incidence of microvascular angina in patients seen in community hospitals and clinics is unknown. These patients usually have a benign clinical course and should be encouraged to lead normal active life.<sup>17</sup> Other cardiac causes of unexplained chest pain may include mitral valve prolapse, hypertension, hypertrophic cardiomyopathy, pulmonary hypertension, and myocardial bridging.<sup>18</sup>

### Musculoskeletal disease

Musculoskeletal causes account for about 10% of cases of noncardiac chest pain.<sup>19</sup> The differential diagnosis includes costochondritis, fibrositis, various arthritides, etc. The pain is worsened with deep respiration and exertion. Local tenderness is usually elicited. Again, the presence of these signs and symptoms however does not preclude a potentially life-threatening cardiac etiology which must always be excluded.

### Psychiatric disorders

Recent reports have suggested that about one-third of patients with chest pain and normal coronary arteries have panic disorder.<sup>20-22</sup> This is a potentially important relationship because panic disorders can be effectively treated. However a definite relationship between panic disorder and chest pain has not been shown. Lantinga et al evaluated patients with chest pain with and without coronary artery disease.<sup>23</sup> Patients' clinical interviews and psychological tests that assessed neuroticism both on the day before cardiac catheterization and 1 year later were done. Patients with noncardiac chest pain scored significantly high scores both pre-catheterization and on follow-up. Only 33% of patients with a normal coronary angiogram were certain that they did not have heart disease. They concluded that the

knowledge that they had no coronary disease by itself resulted in no change in their psychological status.<sup>23</sup>

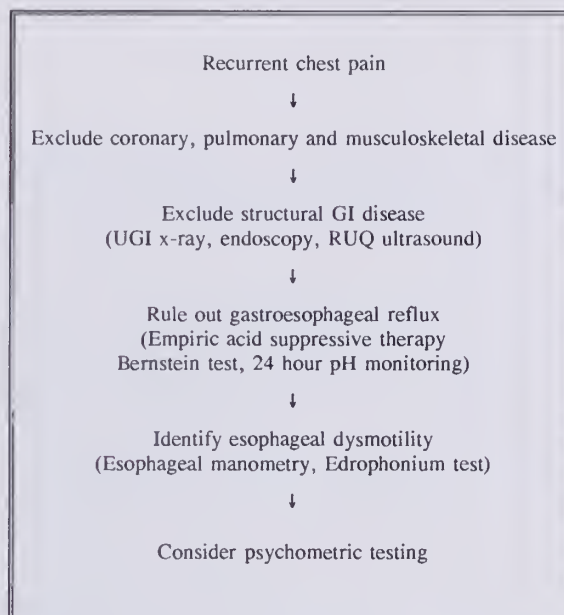
### Altered pain perception

Data suggests that a number of patients with noncardiac chest pain have irritable esophagus analogous to irritable bowel syndrome.<sup>7</sup> Most studies using esophageal balloon distention have suggested that these patients have reduced threshold for esophageal visceral pain.<sup>24</sup> Hypersensitivity during esophageal stimulus seems to be a general finding in noncardiac chest pain of proven esophageal origin.<sup>7</sup> This is suggested by the following observations: (a) patients with positive acid perfusion feel chest pain after an amount of acid that does not induce pain in controls; (b) motility changes in patients with a positive edrophonium test are similar when compared to controls; (c) many normal subjects develop esophageal contractions of greater amplitude and duration than do chest pain patients without feeling pain.<sup>7</sup> The observation of increased perception of catheter movement during angiography in patients with microvascular angina further suggests a change in visceral awareness.<sup>15</sup> Whether this is due to heightened sensory perception or an alteration in central cerebral processing remains to be elucidated.<sup>25</sup>

### Diagnostic strategy

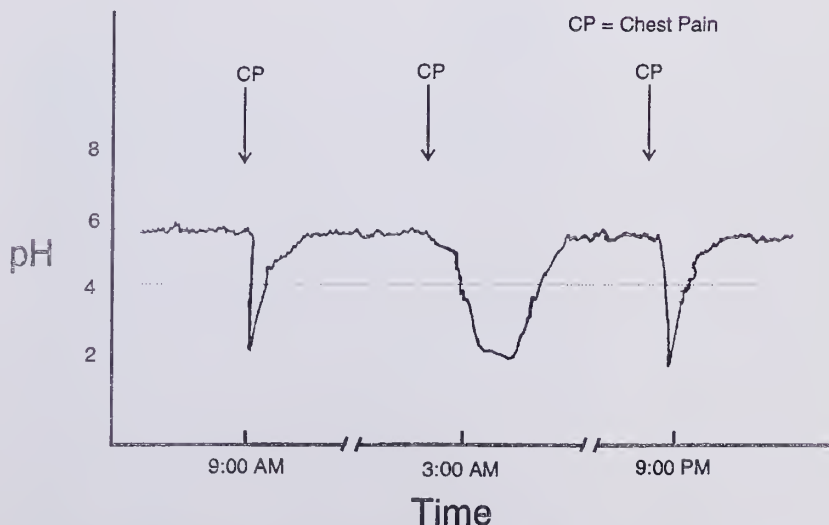
A careful and systematic evaluation should be undertaken (Fig 2). A good history alone may not distinguish cardiac from other causes of chest pain. As such, the evaluation must begin with the careful exclusion of cardiac disease. The evaluation of younger patients should at least consist of a negative EKG during chest pain as well as a negative EKG and a negative stress test. In older patients and in more difficult patients, a coronary angiogram may be needed. If the above studies are negative, the physician's attention should be directed to chest pain syndromes associated with normal coronary arteries.<sup>5</sup> Establishing an appropriate diagnosis is important even though life-threatening cardiac causes have been excluded. This is so because patients suffer much less disability when told of a definite cause for their chest pain.<sup>26</sup>

An organic lesion of the upper gastrointestinal tract should be ruled out by barium studies or endoscopy. If these tests are unrevealing, 24-



**Fig 2 — Suggested diagnostic strategy for recurrent noncardiac chest pain.**

hour pH monitoring, esophageal manometry, and provocative tests may help identify an esophageal cause of chest pain. Although many of the provocative tests do not confidently direct therapy, they may reassure the patient, which is a critical step in treating the problem. Simultaneous ambulatory monitoring of esophageal motility as well as pH may help in evaluation of some of these patients. Esophageal pH monitoring like Holter monitoring can be done in an ambulatory setting (Fig 3). A



**Fig 3 — Ambulatory 24 hour pH tracing showing chest pain (CP) during acid reflux episodes.**



## Noncardiac Chest Pain

symptom index is useful for evaluating pH results since many patients with a normal 24-hour pH score have isolated reflux events at the time of their pain.<sup>27</sup>

A variety of provocative tests to increase the diagnostic yield of unexplained chest pain have been used including Bernstein test for acid reflux and edrophonium test to induce esophageal dysmotility. The role of acid perfusion is decreasing with the advent of 24-hour pH monitoring, which is significantly more sensitive and specific. Graded esophageal balloon distention allows a means of provoking chest pain without use of systemic agents.<sup>28</sup> However, there are limitations to provocative testing. These tests depend on a subjective end point in the patient's perception of pain. Recent investigations with cerebral evoked potentials provide an opportunity of an objective endpoint.<sup>15</sup> All provocation agents can decrease coronary artery reserve and induce angina, thus raising the question of a cardiac source in patients with positive presumed esophageal provocation.<sup>24</sup> As such, many experts recommend a judicious use of these tests. Further work up to exclude other conditions should be individualized. It is important not to overlook psychological factors which can be part of chest pain syndrome or the causative factor. A careful history and simple psychometric testing may identify an existing psychiatric disorder and may lead to the therapeutic trial of a psychotropic drug and behavior modification.

### Treatment

Satisfactory treatment of patients with recurrent noncardiac chest pain is a frustrating experience for both the primary care physician and the specialist. Reassurance goes a long way in improving symptoms in many patients. Proton pump inhibitors and H<sub>2</sub> antagonists provide effective relief of gastroesophageal reflux disease. The doses and the frequency of the drugs needed may be higher than those required for treatment of peptic ulcer disease. Changes in life style such as cessation of smoking and raising the head end of the bed while sleeping lead to significant decrease of acid reflux. Pharmacological treatment of motility disorders has been disappointing. Nitrates, calcium channel blockers, and anticholinergics have demonstrated success in some studies. Bougie-nage with large mercury filled dilators may provide transient relief in some patients with esopha-

geal dysmotility. Pneumatic dilatation is rarely a consideration because of high risk of perforation. Surgical myotomy has been used in some cases of severe chest pain with dysphagia.

Microvascular angina may respond to calcium channel antagonists. Musculoskeletal disorders may require physical therapy, analgesics and nonsteroidal antiinflammatory agents, muscle relaxants, anxiolytics, and antidepressants. Behavioral therapy may be effective in improving chest pain and activity limitation. Alprazolam may be helpful in cases associated with panic attacks. Antidepressants have shown promise in preliminary studies of unexplained chest pain.

### Prognosis

Long term studies have shown that patients with chest pain and normal coronaries have an excellent outlook in terms of being at low risk for myocardial infarction and death.<sup>30,31</sup> However, the morbidity remains high.<sup>18</sup> Simply excluding a cardiac disease is not very reassuring to many patients.<sup>23</sup> They remain physically debilitated or unemployed and continue to visit the Emergency Department. In contrast, once a definite etiology has been established, they tend to cope with their symptoms better with an improved life style.

### Conclusion

Chest pain in patients with normal coronary arteries is a complex and incompletely understood problem. The clinical significance of abnormalities that have been found in the coronary microcirculation, esophageal motility, and psychological function needs to be determined. Recent observations suggest a fundamental abnormality of either visceral nociception or the autonomic nervous system in patients with chest pain and normal coronary arteriogram. Excluding a primary cardiac etiology in such cases is of paramount importance. Diagnostic and therapeutic interventions in such cases need to be individualized. In long term follow-up studies, patients with negative cardiac evaluation and presumed esophageal pain have a low mortality, less disability, and use medical resources to a lesser degree than those without a definable cause for their chest pain.<sup>26</sup>

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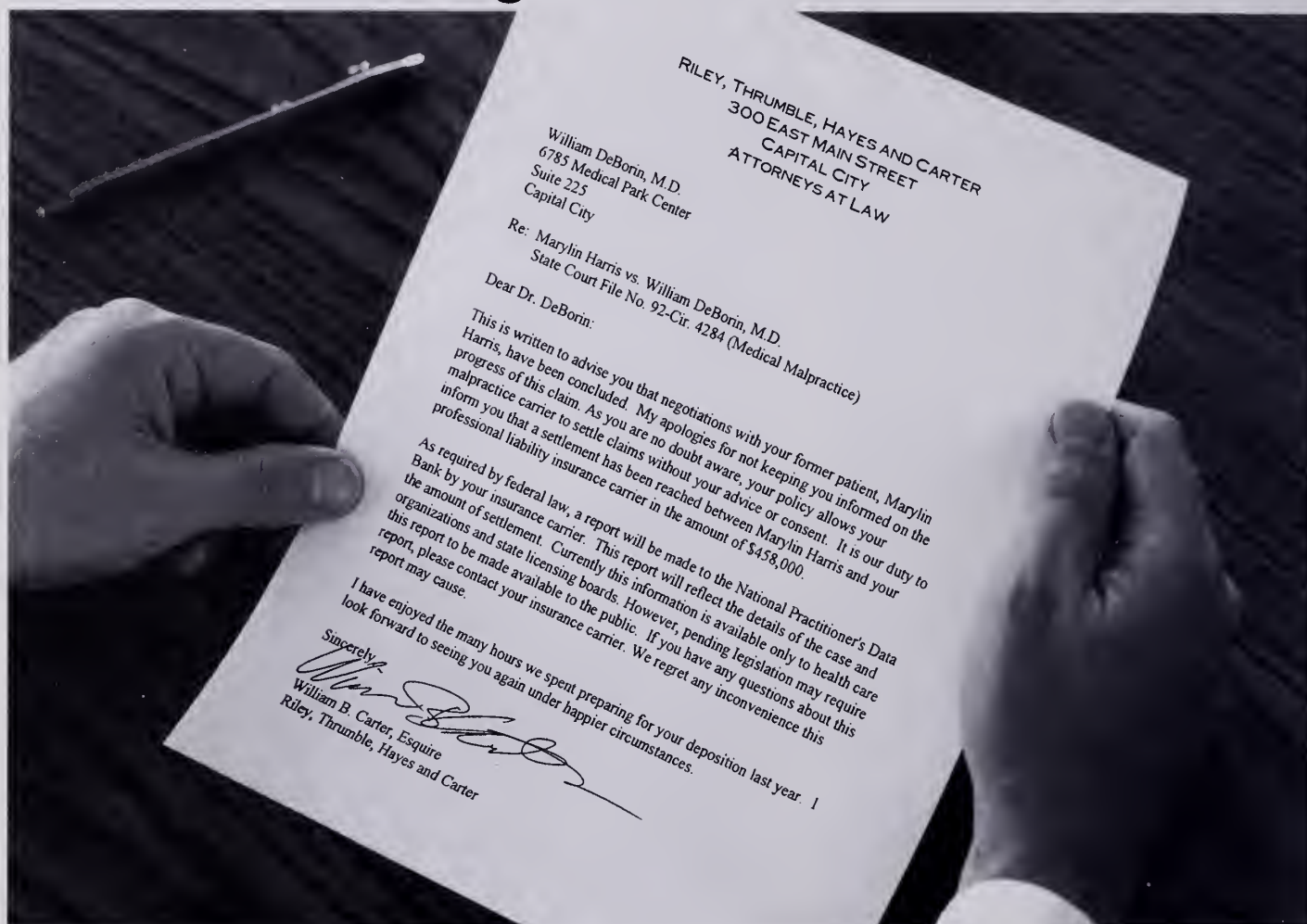
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# Dysphagia: Diagnosis and Treatment in Kentucky

James W. Atchison, DO; Diane Bryan, OTR; Sally Lumm, OTR; Mary Morgan, RD; Nancy Nickerson, MA, CCC-SLP; Angela Niehaus, MS, CCC-SLP; Terry Stratton, MA, CCC-SLP; Richard Salcido, MD

*Dysphagia, a disorder of swallowing, is commonly associated with neurological and neuromuscular disorders. Damage to the sensation or muscles of the swallowing mechanism leads to unsafe oral motor or pharyngeal movement patterns, placing a patient at risk for development of aspiration pneumonia. At present, multidisciplinary Dysphagia Teams are being used to improve the diagnosis and treatment of swallowing disorders. A survey including all 112 hospitals in the Commonwealth of Kentucky indicates 33 (29%) presently have such a team, while 42 (38%) offer outpatient dysphagia services. In addition, 56 (50%) of the hospitals indicate they perform modified barium swallows which is an essential test for diagnosing and treating dysphagia. An example of how a Dysphagia Team works in one Kentucky rehabilitation hospital is presented to illustrate how to provide early diagnosis and treatment of these problems.*

**D**ysphagia is the term used to describe swallowing problems which affect the safety and/or efficiency of swallowing. A person with dysphagia may demonstrate unsafe oral motor or pharyngeal movement patterns,<sup>1,9</sup> decreasing their ability to take in proper amounts of food within appropriate time periods for adequate nutrition,<sup>10-15</sup> or placing them at risk for developing aspiration pneumonia.<sup>16-21</sup>

Dysphagia is often associated with neurological<sup>3, 5, 17, 20, 22, 23</sup> and neuromuscular disorders<sup>3, 7, 22, 24-29</sup> in which damage occurs to sensation<sup>22</sup> or muscles<sup>3, 6, 8, 9</sup> of the swallowing process. Examples of conditions that may precipitate dysphagia are: traumatic brain injury,<sup>22, 30</sup> Parkinson's disease,<sup>31, 32</sup> Alzheimer's disease,<sup>33</sup> cerebral palsy,<sup>34, 35</sup> poliomyelitis,<sup>36, 37</sup> cerebrovascular accident/stroke,<sup>5, 18, 20-23</sup> amyotrophic lateral sclerosis,<sup>38</sup> myasthenia gravis,<sup>39</sup> multiple sclerosis,<sup>40</sup> connective tissue diseases,<sup>29, 41</sup> and muscular dystrophy.<sup>24</sup> Other less

common causes of dysphagia include cancer or surgery of the head and neck,<sup>12-17</sup> tumors,<sup>12, 48</sup> neurological impairments associated with AIDS,<sup>29, 41</sup> and gastroenterologic disorders.<sup>29, 49, 50</sup> In addition, medications such as antibiotics, antiarrhythmics, antihypertensives, benzodiazepines,<sup>51</sup> chemotherapeutic agents, neuroleptics, and antidepressants may also contribute to swallowing difficulties.<sup>29, 52</sup>

Regardless of etiology, the chief concern with individuals who have dysphagia is that food or liquid does not move through the mouth and pharynx normally and may enter the lungs before, during, or after swallowing.<sup>3, 4, 16-20, 22, 53</sup> Symptoms frequently exhibited with dysphagia are: regurgitation of food, drooling, coughing or choking during or after a meal, gurgly/wet voice during or after a meal, poor appetite/weight loss, or discomfort during swallowing.<sup>5, 18, 22, 54</sup> Unfortunately, up to 60% of individuals with dysphagia are "silent aspirators," meaning they do not exhibit any overt symptoms,<sup>22</sup> and dysphagia in these asymptomatic individuals is often overlooked until they develop frequent respiratory infections and/or pneumonia.<sup>3, 17</sup>

Many medical centers have begun to take a more aggressive approach to recognition, prevention, and treatment of dysphagia<sup>4, 55, 56</sup> through the formation of multidisciplinary Dysphagia Teams.<sup>5, 57, 58</sup> These consist of many different healthcare practitioners such as: Speech and Language Pathologists (SLP),<sup>59</sup> Occupational Therapists (OT), Nurses, Respiratory Therapists, Registered Dietitians, and Physicians.<sup>3, 50</sup> The availability of dysphagia services throughout the Commonwealth of Kentucky (Fig 1), plus an example of how a Dysphagia Team may work is the major focus of this article.

## Dysphagia Survey Results

In order to evaluate the availability of diagnostic and therapeutic dysphagia services in the Com-

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## Dysphagia in Kentucky

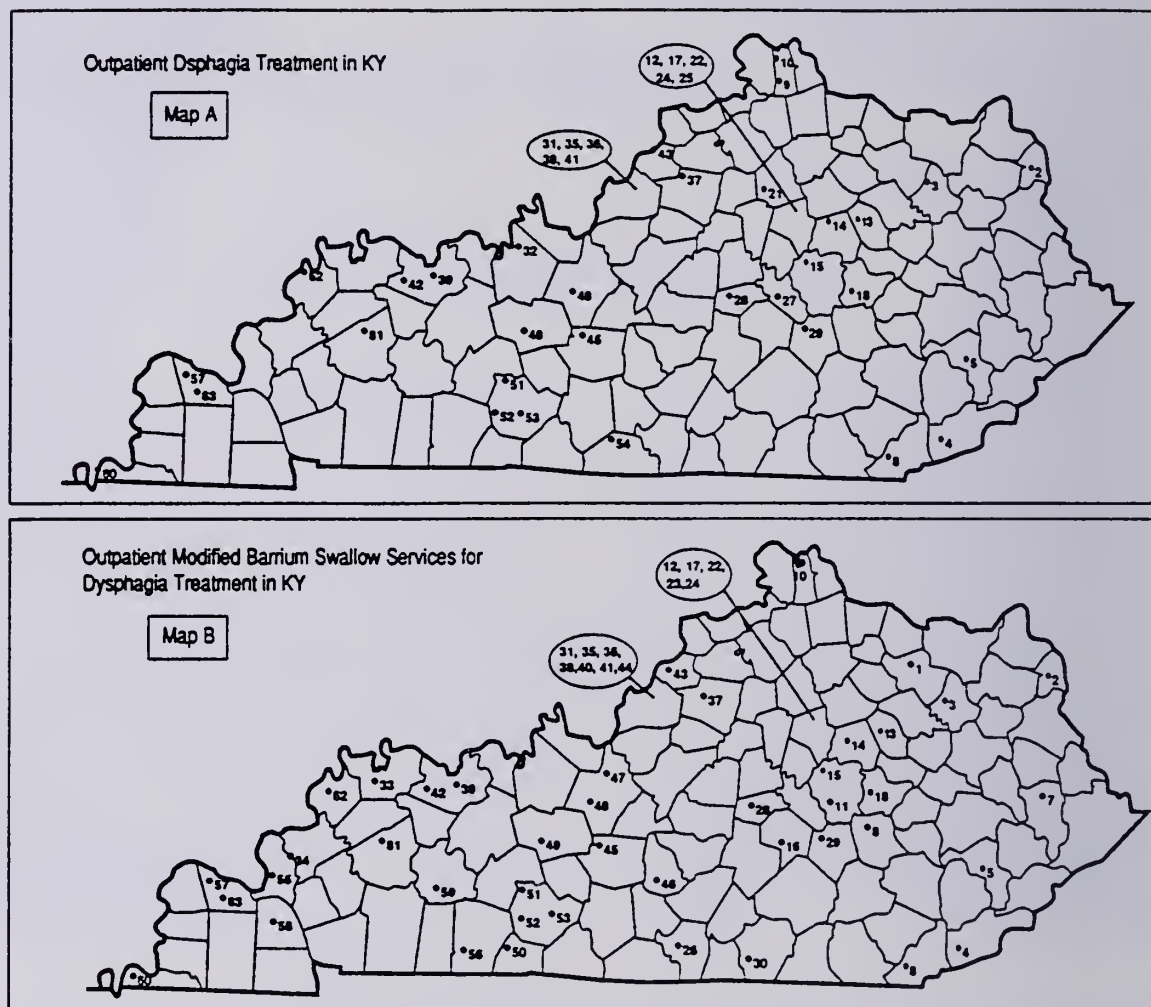


Fig 1— Outpatient Dysphagia Services in Kentucky. (Key to map on facing page.)

monwealth of Kentucky, all hospitals (112) were sent a survey as seen in Fig 2. Two months later a follow-up study was sent to all hospitals that had not responded; and 1 month later a telephone follow-up was placed to each hospital that had not responded to either written request.

Responses were obtained from all 112 (100%) hospitals in the Commonwealth of Kentucky, with 41 (37%) indicating outpatient dysphagia treatment services were available (see Fig 1), 37 (33%) indicating inpatient dysphagia treatment services were available, and 33 (29%) stating that they had a multidisciplinary Dysphagia Team. Altogether, 33 (100%) multidisciplinary teams had a Speech Pathologist, 32 (97%) had a Registered Dietician, 29 (88%) had a Physician, 18 (54%) had a Nurse, 18 (54%) had an Occupa-

tional Therapist, and 10 (30%) had a Respiratory Therapist.

Of the 29 multidisciplinary teams that include a Physician, 90% receive input from a Radiologist, 38% from an Otolaryngologist, 31% from a Gastroenterologist, 27% from a Pulmonologist, and 24% from a specialist in Physical Medicine and Rehabilitation. The patients' Primary Care or Referring Physician were also included if they so desired in 7 (24%) of the teams.

There were 56 (50%) hospitals in the Commonwealth of Kentucky indicating that they performed modified barium swallows (MBS) to assess dysphagia. Of these facilities, 53 (see Fig 1) accept outpatient referrals for these procedures. All 56 (100%) centers had a Radiologist present for the MBS, while 35 (63%) had an SLP present,

## LOCATION LISTING

No.	Hospital Name, City	County	Map
<u>Northeast</u>			
1.	Fleming County Hospital **, Flemingsburg	Fleming	B
2.	Kings Daughters Medical Center, Ashland	Boyd	A,B
3.	St. Claire Medical Center, Morehead	Rowan	A,B
<u>Southeast</u>			
4.	Harlan Appalachian Regional Hosp, Harlan	Harlan	A,B
5.	Hazard Appalachian Regional Hosp, Hazard	Perry	A,B
6.	Kentucky River Medical Center, Jackson	Breathitt	B
7.	McDowell Appalachian Reg Hosp **, McDowell	Floyd	B
8.	Middlesboro Appalachian Reg Hosp, Middlesboro	Bell	A,B
<u>North Central</u>			
9.	Northern Ky Rehabilitation Hosp, Edgewood	Kenton	A,B
10.	St. Elizabeth Medical Center, Covington	Kenton	A,B
<u>Central</u>			
11.	Berea Hospital, Berea	Madison	B
12.	Central Baptist Hospital, Lexington	Fayette	A,B
13.	Mary Chiles Hospital, Mt. Sterling	Montgomery	A,B
14.	Clark Regional Medical Center, Winchester	Clark	A,B
15.	Pattie A. Clay Hospital, Richmond	Madison	A,B
16.	Fort Logan Hospital **, Stanford	Lincoln	B
17.	Good Samaritan Hospital, Lexington	Fayette	A,B
18.	Marcum & Wallace Memorial Hosp **, Irvine	Estill	A,B
21.	Scott General Hospital, Georgetown	Scott	A
22.	St. Joseph Hospital, Lexington	Fayette	A,B
23.	University of Kentucky Medical Ctr, Lexington	Fayette	B
24.	V. A. Medical Center, Lexington	Fayette	A,B
25.	Cardinal Hill Rehabilitation Hosp, Lexington	Fayette	A
<u>South Central</u>			
26.	Cumberland County Hospital **, Burkesville	Cumberland	B
27.	Garrard County Memorial Hospital, Lancaster	Garrard	A
28.	Ephraim McDowell Reg. Medical Ctr, Danville	Boyle	A,B
29.	Rockcastle County Hospital, Mt. Vernon	Rockcastle	A,B
30.	Wayne County Hospital, Monticello	Wayne	B
<u>Northwest</u>			
31.	Baptist Hospital East, Louisville	Jefferson	A,B

No.	Hospital Name, City	County	Map
32.	Breckenridge Memorial Hospital, Hardinsburg	Breckinridge	A
33.	Community Methodist Hospital #, Henderson	Henderson	B
34.	Crittenden County Hospital, Marion	Crittenden	B
35.	Frazier Rehabilitation Hospital, Louisville	Jefferson	A,B
36.	Jewish Hospital, Louisville	Jefferson	A,B
37.	Jewish Hospital - Shelbyville	Shelby	A,B
38.	Kosair Children's Hospital ?, Louisville	Jefferson	A,B
39.	Mercy Hospital, Owensboro	Daviess	A,B
40.	Methodist Evangelical Hospital ?, Louisville	Jefferson	B
41.	Norton Hospital, Louisville	Jefferson	A,B
42.	Owensboro-Daviess Co. Hosp, Owensboro	Daviess	A,B
43.	Tri-County Baptist Hosp, LaGrange	Oldham	A,B
44.	V.A. Medical Center, Louisville	Jefferson	B
<u>Midwest</u>			
45.	Caverna Memorial Hosp **, Horse Cave	Hart	A,B
46.	Jane Todd Crawford Mem. Hosp **, Greensburg	Green	B
47.	Hardin Memorial Hosp, Elizabethtown	Hardin	B
48.	Lakeview Rehab Hosp, Elizabethtown	Hardin	A,B
49.	Twin Lakes Reg. Med Center, Leitchfield	Grayson	A,B
50.	Franklin-Simpson Mem. Hosp #, Franklin	Simpson	B
<u>Southwest</u>			
51.	Greenview Hosp **, Bowling Green	Warren	A,B
52.	Medical Center at Bowling Green ?	Warren	A,B
53.	Mediplus Rehab Hosp, Bowling Green	Warren	
<u>West</u>			
54.	Monroe County Medical Center, Tompkinsville	Monroe	A
55.	Livingston County Hosp **, Salem	Livingston	B
56.	Logan Memorial Hosp, Russellville	Logan	B
57.	Lourdes Hospital, Paducah	McCracken	A,B
58.	Marshall County Hosp, Benton	Marshall	B
59.	Muhlenberg Community Hosp, Greenville	Muhlenberg	B
60.	Parkway Regional Hosp ?, Fulton	Fulton	A,B
61.	Regional Medical Center, Madisonville	Hopkins	A,B
62.	Union County Methodist Hosp, Morganfield	Union	A,B
63.	Western Baptist Hosp, Paducah	McCracken	A,B

**Key:** # Thin Barium only  
 \*\* Thin and Thick Barium only  
 ? Unknown consistencies

33 (59%) had a specially trained Radiology Technician, and 8 (14%) had an OT present to perform the studies.

The majority of these facilities (89%) indicated that they can perform the test with thin liquid Barium, while 80% of facilities indicated the ability to perform some or all of the other consistencies (thickened liquids, paste, or cookie). Thirty-four (61%) of the facilities could perform the test with all consistencies plus changes in head and neck position (see Fig 1). Sixty percent (32) of the facilities accepting outpatient referrals indicated that dietary recommendations could be made by their Dysphagia Team following the MBS, while the other facilities per-

formed the test and returned the patient to the referring source.

In terms of continued education and growth of dysphagia services throughout the Commonwealth of Kentucky, 30 (26.7%) hospitals indicated they would like more information about establishing a multidisciplinary Dysphagia Team, and 36 (32.1%) would like more information about performing MBS with multiple dietary textures and positioning techniques.

### Initial Evaluation

In the rehabilitation hospital setting, recognition and treatment of dysphagia begins at the time of



## Dysphagia in Kentucky

admission. If the patient has a history of dysphagia or aspiration while in the acute care hospital, the patient is automatically referred for a Dysphagia Team evaluation. All other patients are screened by the admitting nurse for symptoms of dysphagia by interviewing the patient and family, and observing behavior at the first meal. If a potential or confirmed swallowing problem exists as evidenced by coughing or choking during or after drinking/eating, slowed or uncomfortable swallowing, a gurgly voice quality, or unexplained temperatures, a bedside Dysphagia Team evaluation is recommended and a physician's order is written.

After receiving the physician's order, an SLP and OT review the patient's case history in the medical chart, which includes diagnosis, respiratory status, mental status, and present nutritional intake including liquid consistency, food texture, and/or type of non-oral nutrition.<sup>11, 59, 60</sup> A bedside dysphagia evaluation is then performed by the SLP and OT. This consists of an assessment of the patient's oral motor skills, which includes labial and lingual structure and function, velar competence, and laryngeal function.<sup>5, 54, 61</sup>

The next step is to introduce various liquid consistencies and solid textures in small amounts for the patient to swallow while SLP and OT observe. Assessment of ability to propel the liquid/solid bolus posteriorly; initiation and timeliness of the pharyngeal swallow; laryngeal elevation; vocal quality; presence of choking/coughing before, during or after swallows; and/or complaints of discomfort/obstruction during swallowing are documented.<sup>5, 54, 62, 63</sup> If dysphagia is suspected based on the patient's bedside performance, a treatment plan is developed. This includes recommendations for a safe liquid consistency and food texture,<sup>63, 64</sup> specific therapeutic swallowing maneuvers,<sup>2, 53, 61, 65-67</sup> a supervised therapeutic feeding group, and/or recommendations for a more definitive evaluation, such as a modified barium swallow.

### Imaging Studies

A modified barium swallow (MBS), also called the cookie swallow or videofluoroscopy, is a radiographic study of swallowing that records on video, movement of the bolus orally through the pharynx and into the esophagus.<sup>1, 3-5, 68</sup> The study allows the radiologist, SLP, and OT immediate observation and diagnosis of swallowing pathology as it occurs, and is more sensitive than bed-

side testing for identification of swallowing abnormalities.<sup>22, 54</sup> While a very sensitive test, the MBS is generally regarded to be nonspecific for identifying abnormalities associated with individual neuromuscular or neurological disease states.<sup>1, 3, 4, 17</sup>

The MBS uses many forms of barium, including paste, cookies dipped in barium, and various liquid consistencies, as well as anterior/posterior and lateral views to analyze swallowing.<sup>1, 3, 5, 68</sup> These help to determine: (1) the exact location of the difficulty; (2) whether and why aspiration is occurring; (3) on what types of liquid/food consistencies aspiration occurs; (4) the anatomy and physiology of the pharynx and esophagus.<sup>1, 3, 5</sup> The MBS also allows evaluation of multiple swallows, which makes it possible to determine the effects of posture and various therapy maneuvers in eliminating and/or improving the efficiency and safety of the swallow.<sup>1-3, 53, 65, 66, 68</sup> In addition, repeat MBS testing carries a low risk of complication<sup>69</sup> and may help to monitor a patient whose swallowing problems are responding to treatment,<sup>5, 70</sup> or deteriorating.<sup>2, 3</sup>

Other imaging techniques presently available include scintigraphy,<sup>16, 47</sup> endoscopy,<sup>5, 71</sup> videoendoscopy,<sup>57, 72</sup> laryngoscopy,<sup>5</sup> ultrasound,<sup>57, 71</sup> and magnetic resonance imaging.<sup>48</sup> These tests are not as routinely used or available as the MBS, but may give more specific visual information about certain details of the swallowing process. In addition, electromyography,<sup>57, 73</sup> manometry,<sup>74-76</sup> and electroglottography<sup>77</sup> are being used to assess proper swallowing.

Of these newer tests, scintigraphy is the most useful diagnostically because it can objectively quantify the amount of aspiration occurring with dysphagia; and early data suggests that an aspiration percentage as low as 7% to 12% will lead to pneumonia.<sup>16</sup> Videoendoscopy, ultrasound, electroglottography, and electromyography are also being used for diagnostic purposes, but may eventually show more benefit in biofeedback-like treatment programs.<sup>57, 78</sup>

### Dysphagia Treatment

The primary goals of treatment are safety during swallowing and adequate nutritional intake. Several issues to be considered for successful feeding include: (1) the environment,<sup>5, 30</sup> (2) positioning,<sup>2, 5, 53, 65, 66, 68, 76</sup> (3) the food or liquid to be given,<sup>5, 61, 63, 64</sup> (4) oral phase disorders,<sup>1, 3</sup> and (5) pharyngeal phase disorders.<sup>1, 3, 4, 33</sup>

Environmental factors must be considered for patients with attention and/or cognitive deficits.<sup>5,79</sup> For example, noisy, cluttered, or busy areas can be very distracting for persons with dysphagia. A structured (quiet, organized, and pleasant) environment during meals allows patients to concentrate on specific techniques for feeding.<sup>30</sup>

Positioning can also facilitate safe swallowing.<sup>1, 3, 5, 53, 67, 68, 76, 79</sup> Keeping an upright, symmetrical posture in sitting, with hips at 90°, can control abnormal muscle tone. If head control is a problem, a head support may be needed. Likewise, if trunk control is a problem, back supports or other positioning devices may be necessary.

Treating individuals with dysphagia may also involve changing the consistency of foods or liquids,<sup>5,61,63,64,68</sup> or if necessary, eliminating some consistencies in order to make swallowing safer. The consistency will vary according to the person's ability to handle liquids/foods in the oral cavity, form a bolus, and swallow efficiently. Liquids are classified as thin (such as water), mildly thick (such as nectar), moderately thick (such as honey), or extra thick (such as pudding). Foods may be pureed, mechanical soft (chopped), soft, or regular textures. In general, individuals with dysphagia secondary to neuromuscular disorders have the most difficulty swallowing thin liquids and regular solid textures.<sup>63</sup>

Treatment techniques for oral phase disorders may include lip and tongue exercises to strengthen and improve coordination and/or mobility.<sup>57,61,62</sup> Physical manipulation may include assisting in lip closure or jaw mobility.<sup>5,62</sup> Compensatory techniques utilized may include: (1) monitoring the size of the bolus,<sup>1,68,80,81</sup> (2) placing the food to the stronger side of the oral cavity to aide in bolus formation,<sup>53,62</sup> (3) changing the liquid consistency and/or diet texture to aid in the oral manipulation, mastication, or bolus formation of the food,<sup>5,63,68</sup> and (4) changing the head tilt position.<sup>2,53,65,66,68,70</sup>

Treatment techniques for pharyngeal phase disorders may include a variety of techniques depending upon the problem.<sup>5</sup> Changing the diet texture or liquid consistency is one technique.<sup>5,63,68</sup> Turning or tilting the head or tucking the chin<sup>2,53,62,65,66,68,70,76</sup> may be useful to make swallowing safer or easier. Other techniques include multiple swallowing to reduce residue or pooling in the pharynx.<sup>62</sup>

The supraglottic swallow<sup>53,62,70</sup> is used to protect the airway through the process of holding

# DYSPHAGIA SURVEY CARDINAL HILL REHABILITATION HOSPITAL

Name of your hospital \_\_\_\_\_

I. Do you have a Dysphagia Team? \_\_\_\_\_ Yes \_\_\_\_\_ No

A. If so, which professional disciplines are represented? (check all that apply)

\_\_\_\_\_ Speech and Language Pathology

\_\_\_\_\_ Occupational Therapy

\_\_\_\_\_ Physician

\_\_\_\_\_ Respiratory Therapy

\_\_\_\_\_ Nursing

\_\_\_\_\_ Registered Dietician

Other: \_\_\_\_\_

B. The physicians on the team represent which specialties? (check all that apply)

\_\_\_\_\_ Radiology \_\_\_\_\_ Pulmonology

\_\_\_\_\_ Ear, Nose & Throat \_\_\_\_\_ Gastroenterology

\_\_\_\_\_ Physical Medicine and Rehabilitation

Other: \_\_\_\_\_

II. Does your hospital perform modified barium swallows (videofluoroscopy)? \_\_\_\_\_ Yes \_\_\_\_\_ No

A. Which of the following consistencies are used during the study? (check all that apply)

\_\_\_\_\_ Thin liquid

\_\_\_\_\_ Mild thick liquid (nectar)

\_\_\_\_\_ Moderate thick liquid (honey)

\_\_\_\_\_ Thick liquid (pudding)

\_\_\_\_\_ Barium cookie

B. Is the study performed with changes in position of the head and neck? \_\_\_\_\_ Yes \_\_\_\_\_ No

C. Which disciplines are present during the exam? (check all that apply)

\_\_\_\_\_ Radiologist

\_\_\_\_\_ Speech and Language Pathologist

\_\_\_\_\_ Occupational Therapist

\_\_\_\_\_ Specially Trained Radiology Tech

III. Do you accept referrals for modified barium swallows (videofluoroscopy) from outside sources? \_\_\_\_\_ Yes \_\_\_\_\_ No

A. If so, does the dysphagia team make recommendations regarding diet texture and consistency? \_\_\_\_\_ Yes \_\_\_\_\_ No

IV. Do you have outpatient dysphagia treatment services? \_\_\_\_\_ Yes \_\_\_\_\_ No

A. If so, which professional disciplines are involved with the treatment? (check all that apply)

\_\_\_\_\_ Speech and Language Pathology

\_\_\_\_\_ Occupational Therapy

\_\_\_\_\_ Physician

\_\_\_\_\_ Respiratory Therapy

\_\_\_\_\_ Nursing

\_\_\_\_\_ Registered Dietician

Other: \_\_\_\_\_

V. If you do not have a Dysphagia Team would you like information on: (check all that apply)

\_\_\_\_\_ Establishing an interdisciplinary Dysphagia Team

\_\_\_\_\_ Performing modified Barium swallows (videofluoroscopy) with multiple dietary texture and positioning

Fig 2 — Dysphagia Survey.

one's breath while swallowing, coughing immediately afterward, and then swallowing a second time. The Mendelsohn maneuver<sup>53,57,61,62,68</sup> is used to facilitate elevation of the larynx, thereby protecting the bolus from entering the airway. Thermal stimulation<sup>53,62,82</sup> at the anterior faucial arches with a cold laryngeal mirror may enhance sensitivity and improve initiation of a swallow for persons exhibiting a delayed pharyngeal swallow.



## Dysphagia in Kentucky

And finally, exercises may be useful to improve vocal fold adduction, base of the tongue movements, and laryngeal elevation.<sup>5,57,61</sup>

### Dietary Modifications

Diets that are modified to allow safe swallowing are classified as pureed, mechanical soft, and soft in texture<sup>5,63,64</sup> (see Table 1). A pureed diet<sup>12</sup> may be required for a person with severe dysphagia and is the most limiting of substances. It is the same consistency as baby food, but may include pureed meats served with gravy, pureed fruits and vegetables, mashed potatoes, cooked cereals such as cream of wheat and oatmeal, cottage cheese, and pureed scrambled eggs. Acceptable desserts include pudding, gelatin, custard, ice cream, and sherbet. Cold cereals and bread are not allowed for the patient receiving pureed textures.

As the patient's dysphagia improves, their diet may advance to a mechanical soft texture. This includes chopped meats and vegetables, scrambled or soft cooked eggs, cooked and flaked cereals, and pasta such as rice, macaroni, chopped spaghetti, and noodles. Canned fruits should be without tough skins or seeds, and sliced bananas are allowed. Loaf bread and cakes are acceptable. Foods to avoid on the mechanical soft texture include bacon, peanut butter, celery, fresh green peppers, asparagus, raisins, and toast.

As the dysphagia continues to improve, the patient may advance to a soft textured diet. This diet allows baked, broiled, or roasted meats, cottage cheese, and peanut butter. Vegetables should be cooked soft with the exception of fresh peeled cucumbers and tomatoes or shredded lettuce. Canned and baked fruits without skin are acceptable as are bananas, melons, strawberries, and grapes. Breads, cereals, pies, and cookies without nuts or coconut are allowed. Foods to avoid on the soft texture diet include fried meats or vegetables and bacon.

Many patients with dysphagia require thickened liquids in addition to their texture modifications. Thickened liquids may be categorized as mild, moderate, and extra thick.<sup>5,63,64</sup> Mild thick liquids are the consistency of buttermilk, V-8 juice, and apricot nectar. Moderate thick liquids are honey consistency, and extra thick liquids are pudding consistency. Any liquid may be thickened to the appropriate level with the addition of artificial thickener. The thicker liquids, however, are usually less appealing to the patient. Patients on the thickened liquids do not receive thin liquids, even water, or foods that melt at room temperature such as ice cream, sherbet, or gelatin.

### Conclusion

The diagnosis and treatment of dysphagia is complex. It requires a thorough knowledge of the normal anatomy and physiology of swallowing, as well as recognition of signs and symptoms of dysphagia that may be present during the bedside screening examination. The use of an appropriate diagnostic procedure such as the modified barium swallow is often necessary to determine the presence of a swallowing abnormality. The recommendation of appropriate liquid consistencies and solid textures for safe swallowing is also a key component of dysphagia management. Use of compensatory maneuvers and continued con-

Table 1. Texture Modified Diets

Pureed	Mechanical Soft	Soft
<b>Meat</b> Pureed-baked, brailed, roasted, served with gravy, pureed scrambled eggs, pureed cottage cheese, cheddar cheese.	<b>Meat</b> Chopped-baked, brailed, roasted. Served with gravy. Scrambled eggs, soft cooked eggs. Salad meats. Na bacon, peanut butter.	<b>Meat</b> Baked, brailed, roasted. Na fried meats except eggs. Cottage cheese, smooth peanut butter. Na bacon.
<b>Vegetables</b> Pureed only Mashed potatoes	<b>Vegetables</b> Chopped-soft vegetables. Na asparagus, celery, green pepper, nane fresh. Rice with gravy. Chopped dried beans, limas, green peas, creamed corn.	<b>Vegetables</b> Soft, nane fried, nane fresh. Except: peeled cucumbers, peeled tomatoes, shredded lettuce.
<b>Fruits</b> Pureed only Nectar juices Juices	<b>Fruits</b> All canned without tough skin or seeds. Crushed pineapple, sliced bananas. Na raisins.	<b>Fruits</b> All canned or baked fruit without skin. Nane fresh except: bananas, melons, strawberries, grapes.
<b>Breads &amp; cereals</b> Cooked cereal, oatmeal. Na cold cereal. Na bread.	<b>Breads &amp; cereals</b> Loaf bread only. Na toast. Cooked cereal, Rice Krispies, Sugar Pops, flaked cereal. Pancakes with syrup. Rice, macaroni, chopped spaghetti and noodles.	<b>Breads &amp; cereals</b> Plain breads without nuts. All cereals except those with nuts.
<b>Desserts</b> Pudding, gelatin, custard, ice cream, sherbet, whipped topping.	<b>Desserts</b> Same as pureed, plus cake.	<b>Desserts</b> Same as mechanical soft, plus plain cakes, pies, cookies. Na nuts or coconut.

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sultation and follow-up will ensure that the person with dysphagia enjoys safe oral intake of food and liquid without compromising his or her health or nutritional status.

Though this is one example of how a Dysphagia Team works to assist with diagnosis and treatment, there are many combinations of healthcare professionals available throughout the Commonwealth of Kentucky to provide these services. The most important issue is to utilize these multidisciplinary teams as early as possible to recognize a swallowing disorder and manage it appropriately for the health and nutrition of the patient.

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# Protecting Patient Integrity

**P**rivacy has become a valuable commodity. No newspaper lacks some story revealing details of someone's life. Nominees are x-rayed, then scanned, and finally put through the magnetic extractor to find something controversial, maybe even germane to the appointment. Asked in advance for possible skeletons, some forget, others try to keep the closet closed, but all accept the inevitable opening of all locks in the process.

That we, as physicians, ask many questions, frequently strip the patient literally and figuratively, and then put this information in hard copy makes me wonder about how we fit in this inquisitive and now sometimes mean-

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*"Nominees are x-rayed, then scanned, and finally put through the magnetic extractor to find something controversial, maybe even germane to the appointment."*

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spirited world. Not too many presidential election times ago, Senator Eagleton from Missouri defaulted from the vice presidential position, when his depressive illness and treatment became public knowledge. Previous lymphoma, heart maladies, and disabilities color the candidate with gray, rather than the superman red, white, and blue. Insurance companies ask me to tell about my patients, despite the fact

that there seems little relevance to their charge. Probably the sheer weight and number of forms crushes some of the eagerness to challenge and filter what is being asked and what to disclose.

Recently not only the patient's life is for display. Hospitals, insurance companies, and "health provider organizations" in the medical arena, credit companies, banks, and virtually every new appliance manufacturer in the sectarian world, and many religious organizations push the information buttons regularly. Sometimes I do not answer, often disregard, but other times either I answer or bear significant consequences.

The recent medical college aptitude exam application asked, in the voluntary section, intimate details about the applicant, from the financial status of parents, to living quarters and preferences. Such information clearly has nothing to do with admission, but supplies details that obviously have importance to the askers.

Recently the interim Chief of Police of Louisville pronounced that he will not accept the permanent appointment, that he will retire imminently, and that he had baggage from trips in his past that he assumed would be left in storage. Another example of losing people for jobs that need specific talent. Administrations, on the local, state and national level, previously gathered capable men and women, mostly judged on their skills and intellect, to help govern and run the show. Excluding them basically started from significant character flaws, legal problems, or lack of

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*"The public world commands those matriculating in it to wear light clothing, sometimes even see-through and revealing."*

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appropriate qualifications. This litmus test based itself on legitimate concentrations of bad substance, rather than variations. More and more good people eliminate themselves, rather than face the intrusion into their lives. Our loss as a society is not recoverable, only partially resupplied.

I find myself asking my patients only those questions focused on their present problems. Their privacy is skewed enough by the inevitable medical record, words which are discoverable to many sources. This patient today may be reaching for new positions and responsibilities tomorrow. To shackle them with gist for name calling in the future is to fail them now as a confidant. I am careful not to talk about patients at home, with friends, and sometimes even with other physicians unless my purpose is to help my patient.

The public world commands those matriculating in it to wear light clothing, sometimes even see-through and revealing. Enough will be said about them, if they decide to enter the arena. The concern for our personal integrity should be sublimated into an equal care for our patients.

**Stephen Z. Smith, MD**



# KMA DOMESTIC VIOLENCE AWARENESS SEMINAR

May 20, 1995  
9:00 a.m. - 2:00 p.m.  
Hyatt Regency Hotel, Louisville

» » » *Target Audience: Physicians, Nurses, and Other Health Care Providers*

## **SPEAKERS:**

BARETTA R. CASEY, MD, Chair, KMA Subcommittee on Domestic Violence

GEORGE R. NICHOLS, II, MD, Office of Medical Examiner

LEAH H. DICKSTEIN, MD, University of Louisville, Department of Psychiatry

KATHY FREDERICH, Adult Protection Specialist, Adult Protective Services, Cabinet for Human Resources

RICHARD F. JONES, MD, Farmington, Connecticut, Past President, American College of Obstetrics and Gynecology

THE KENTUCKY MEDICAL ASSOCIATION DESIGNATES THIS CONTINUING MEDICAL EDUCATION ACTIVITY FOR 4 CREDIT HOURS IN CATEGORY 1 OF THE PHYSICIAN'S RECOGNITION AWARD OF THE AMERICAN MEDICAL ASSOCIATION.

THE KENTUCKY MEDICAL ASSOCIATION IS ACCREDITED BY THE ACCREDITATION COUNCIL ON CONTINUING MEDICAL EDUCATION TO SPONSOR CONTINUING MEDICAL EDUCATION FOR PHYSICIANS.

For registration information, contact the KMA at (502) 426-6200. The fee is \$35.00 prior to May 10, and \$50.00 thereafter.

For information on obtaining nursing contact hours, contact Mr. Jack Kelly, KMA Headquarters.

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## **EDUCATIONAL OBJECTIVES**

During the seminar, speakers will:

- ⇒ Discuss and stress the need for health care providers to know the signs and symptoms of spouse abuse in their patients.
- ⇒ Discuss the importance of documentation and reporting of suspected abuse.
- ⇒ Review statistics about victims of domestic violence and the role of the provider to help lower the statistics.
- ⇒ Review the involvement of health care providers in the legal arena when reporting suspected abuse in patients.
- ⇒ Discuss communication techniques and questions which are essential for discussing domestic violence with patients.



Marla Vieillard

## Shared Vision and Voice Is the Right Choice — Together Everyone Achieves More

The Kentucky Medical Association Alliance has always been a team player. We have visions that we share with our physician spouses; shared visions with the American Medical Association Alliance in their national programs to fight breast cancer and violence; shared vision and voice in our county's health promotion projects and legislative endeavors. By sharing our vision and voice we can still achieve more in 1995-1996. In our efforts to fight street violence, strengthen gun control laws, and to fight domestic violence that shatters so many of our families, we have neglected another form of violence. These conditions create "The Inner Web of Violence" for those afflicted and their families who support them emotionally and possibly financially. Yes, I'm referring to depression, bipolar disorders, and other mood disorders.

The spider's web to a fly, moth, or any insect is a trap that usually means death, without help from an outside source. To people, inner violence is like the spider's sticky intricate web. They are caught,

trapped, living on the intricate, delicate threads. If these people are not released, the end result may be death. Fifteen percent to 20% of the cases of depression end in suicide. We have medicine and therapy to help dissolve the web and release the individual to be a normal, productive, and creative person. Major depressive disorders, often referred to as depression, is a common illness that can affect anyone. About 1 in 20 Americans, that's over 11 million people, get depressed every year. Depression affects twice as many women as men. At some time during their lifetimes, as many as 50% of Americans suffer from a major psychiatric illness. Your boss, friend, family member, fellow physician, or Alliance member may be struggling, stuck in the sticky threads that pull them downward and inward. A family, friend, or associate may not always see the change if it's gradual, or if you don't see the person on a regular basis. This individual is having a daily violent battle with themselves to function, go to work or school, eat properly, sleep at normal times,

communicate, and relate appropriately. They don't always realize they have an illness. They feel they have been dealt a bad hand in life's poker game, and they want out!!!

Upon seeing scars on a person's arms and wondering, I asked if they were self inflicted. The answer — "YES." I asked why. The answer, "It feels so good to let the misery and darkness out." What about the pain? Answer, "The horrible inner feelings, voices, nightmares, and doom are worse — YOU DON'T FEEL A THING." Somewhat stunned, I believed what I was told. Churchill called his depression "My own black dog." He picked the term dog because it always stayed with him. Patty Duke wrote *A Brilliant Madness*, and states "Mental illness scares people. They don't understand it; and they tend to feel uncomfortable with anyone who has it. . . . Some illnesses have many faces and there are many ways people experience these conditions."

I call mood disorders Inner Violence because of the damage it imparts. Mental Health has not been given the proper support or



acknowledgment it deserves. Mental Health, as a word, doesn't have the same impact or image as the word Violence. Funding for research and development to alleviate, eradicate, and develop new therapies and medicine is negligible compared to other diseases. Mental Health needs a Jerry Lewis, Betty Ford, or Elizabeth Taylor to raise funds and establish benefit/fund raisers. The media and government have made great strides in their campaigns to stop smoking, AIDS prevention, violence, drug and alcohol abuse. Can you remember a government commercial or recite a jingle about help for mood disorders? There are a few private care center commercials, but we need so much more information to be knowledgeable on Inner Violence.

We need employer, personal, and community acceptance that many of these mood disorders are treatable, like diabetes, hypothyroidism, alcoholism, and drug abuse. Regaining one's health and being productive should be a major incentive to seek treatment. Yet, many will not until the stigma is removed, and the fear that their employer or

friends will find out and abandon them. The insurance carriers need to see that they are part of the problem too. Cancelled and inadequate insurance coverage will stop treatment for most individuals. Many mood disorders overlap with alcohol and drug abuse since the individual is searching for a self help to survive the bad, black dog days. The taboo on getting help for drug or alcohol abuse has been lifted; let it also be for mood disorders.

These people are often intellectuals or creative. This in no way means that only the intellectual or creative are at potential risk for mood disorders. Statistics have shown there is only a predisposition for some of these illnesses. Thomas Edison, Ernest Hemingway, Abraham Lincoln, Robert Lowell, Vincent Van Gogh, Virginia Woolf, Edgar Allan Poe, Lord Byron, Oliver Cromwell, Menachem Begin, Robert Campeau, John Mulhern Jr, Patty Duke, Kristy McNichol, Tracy Gould, Bonnie Raitt, Mike Wallace, Rona Barret, Art Buchwald, Dick Clark, Dick Cavett, Betty Davis, Denton Cooley, Jim Leher, George McGovern, Jean

Seeberg, George Sand, Rod Steiger, and Liz Carpenter start a list of those we know. After treatment some of these current celebrities are starting to help erase the stigma attached to these illnesses. This is a start, a positive jolt, to recovery and the need to seek help.

As we continue with our national campaigns to reduce media, gun, and physical violence, don't forget the need to start a campaign for Inner Violence help. With a vision for their improved health and a team approach, we can and will continue the fight against all types of violence.

Our daughter, Amie, is a "positive" example of what awareness, family support, and therapy can do to fight inner violence. T.E.A.M. is an anachronism for Together Everyone Achieves More. I want to achieve more, not to say that the Alliance has not achieved its goals, but to continue with what we have started and to branch and reach out in a new direction. Shared Vision and Voice is the Right Choice; Together Everyone Achieves More.

**Marla Vieillard**  
KMA Alliance President

# **The Physicians of Tomorrow Mentoring Program**

The American Medical Association and Girl Scouts of America are working together in an exciting new program -

## **The Physicians of Tomorrow Mentoring Program**

- that will encourage and help Cadette and Senior Girl Scouts explore the wide range of realities and opportunities of a career in medicine.

Women physicians are encouraged to serve as mentors to these young women.

### **What does a Mentor do?**

- ◆ Encourage girls to continue their pursuit of a medical career.
- ◆ Serve as a resource for professional networking.
- ◆ Provide counsel on career and professional development.
- ◆ Acquaint the girl with values and culture of the work environment.

*The time commitment is small.*

*You will be matched with a girl for one academic year.*

If you are a woman physician who would be interested in volunteering as a Mentor for

### **The Physicians of Tomorrow Mentoring Program**

please contact the Kentucky AMA Chair or the Girl Scouts-Wilderness Road Council:

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#### **American Medical Association**

Donna Skinker, MD  
Department of Pathology and  
Laboratory Medicine  
Markey Cancer Center cc448  
University of Kentucky Medical Center  
800 Rose Street  
Lexington, KY 40536-0093  
(606) 323-6184

#### **Girl Scouts**

Susan V. Miller  
Program Services Director  
Girl Scouts  
Wilderness Road Council  
2277 Executive Drive  
Lexington, KY 40505  
(606) 293-2621  
1-800-475-2621



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**PEOPLE**

**Virginia T. Keeney, MD**, and KMAA member **Carolyn Neustadt** were recently included when six "Women of Distinction" were honored by the Center for Women and Families in Louisville. The honorees, all women 60 and older, joined 47 other women who have been recognized for community service since the awards ceremony began in 1988.

Dr Keeney is a child psychiatrist on the faculty of the University of Louisville School of Medicine and a leader in medical and civic activities. She is associate director of the Bingham Child Guidance Center, a director of the program in medical ethics and medical humanities at the medical school, on the Kentucky Board of Medical Licensure, secretary of the Judicial Council of the Jefferson County Medical Society, and a past president of the Kentucky Academy of Child Psychiatry.

Dr Keeney also is chairman-elect of the Louisville Chapter of the American Red Cross, was its chairman of volunteers for 7 years and was instrumental in forming two Red Cross programs: Winterhelp and We Speak Your Language.

In 1947-48 Dr Keeney worked in a leper colony in Korea, and some 30 years ago she was program director of the Sabin oral polio vaccine campaign, which eliminated polio in Kentucky.

She was the first woman elected to the board of the American Printing House for the Blind, is a past president of the downtown YWCA, now the Center for Women and Families, and has been an active supporter of the Louisville Orchestra.

Dr Keeney's husband, **Arthur H. Keeney, MD**, and their daughter **Martha Keeney Heyburn, MD**, are both ophthalmologists practicing in Louisville.

**Carolyn Neustadt** has been an influence in such disparate fields as child welfare and public television. She helped found Kentucky Youth Advocates to promote public-policy changes regarding children, and Shelter House, which provides alternatives to detention for runaways and troubled youth. She also helped push for reforms in Jefferson County's juvenile-detention system.

Over the past 13 years Mrs Neustadt has focused on ensuring the fiscal health and growth of public-TV station WKPC-15 and is its vice president for development.

A leader in Louisville's Jewish community, she is past president of the National Council of Jewish Women, Louisville Section, and has served on the boards of the Jewish Community Federation and Jewish Community Center. Her other civic interests include Hospice of Louisville.

Mrs Neustadt is the wife of **David H. Neustadt, MD**, a Louisville rheumatologist.

**Willis McKee, Jr, MD**, a Colonel with the Kentucky Army National Guard, has been named State Surgeon for the Kentucky Army National Guard. He was commander of the 475th MASH in Frankfurt.

**Joseph F. Fowler, Jr, MD**, has been included in the publication "The Best Doctors in America" 1994-95. Dr Fowler has been practicing Dermatology in Louisville for 10 years.

the two most effective chemical therapy treatments for ovarian cancer — at least some of the time.

**James R. Bosscher, MD**, assistant professor of obstetrics/gynecology, pre-exposed three laboratory-grown ovarian cancer cell lines to retinoic acid, a naturally occurring component of Vitamin A. He then treated the specimens with a combination of retinoic acid and the two "front-line" chemotherapy treatments — taxol and cisplatin. He found that, in two of three tests, a higher number of cells were killed when pre-exposed to retinoic acid and the chemotherapy was delivered with retinoic acid.

Although the studies are still in the early stages, Dr Bosscher said the treatment could enable physicians to use smaller doses of chemotherapy or possibly continue treatments longer before the patient begins to experience serious side effects.

The method must prove effective through several more research phases before it would be approved for human testing — a minimum of 3 to 5 years, Dr Bosscher said.

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**New Resource Kit Helps Internists be Role Models, Teachers in Office Settings**

If more medical school graduates don't choose to practice internal medicine in the future, there may not be enough of the "right" kind of doctors to meet America's health care needs as the US population ages in unprecedented numbers over the next 2 decades, says the American Society of Internal Medicine (ASIM). A new ASIM resource kit on internal medicine preceptorship programs aims to help ensure this doesn't happen.

According to ASIM, doctors of internal medicine (internists) — by education and systematic style of practice — are considered to be highly skilled at providing continuing,

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**UPDATES**
**Vitamin A May Improve Treatment of Ovarian Cancer**

The University of Louisville reports that early experiments by a U of L researcher indicate that a Vitamin A derivative may boost the impact of

comprehensive care to adults, particularly as they age. Yet last year, only about a quarter of 1994 medical school graduates chose residency training in internal medicine or one of the other primary care specialties (family practice and pediatrics). Of those who choose internal medicine residencies, only about 30% stay in general internal medicine rather than concentrating on subspecialty areas such as oncology, pulmonology, and endocrinology. However, most physician experts say a 50:50 ratio of generalists to specialists will be necessary in the 21st Century.

ASIM is tackling a problem it sees as one of many reasons medical students aren't choosing to train in general internal medicine in greater numbers: the lack of medical student exposure to the "real world" of internal medicine practice and the lack of positive internal medicine role models as a result. Studies show that in-depth understanding of a specialty — and substantive contact with physicians within it — have a major influence on specialty choice. Because medical education and training occur mostly in the teaching hospital, students see little of the challenges and rewards of internal medicine practice and its importance to the health care system.

One of the solutions to this problem, ASIM believes, is for medical schools to require students — as early as their first year — to participate in community-based, internal medicine preceptorship programs. Many medical schools now offer students an opportunity to work in a physician's office. The key is to give as many students as possible the chance to work in ambulatory, internal medicine practice settings.

To encourage development of and participation in such programs, ASIM has compiled a resource kit for *internists* on preceptorship programs nationwide. Funded in part by the Upjohn Company, the kit includes brief profiles of many medical school

preceptorship programs and whether they are in need of internist-preceptors; steps to take to work with medical schools — and to participate in or sponsor a program as an individual internist, group, or state component society of internal medicine; tips and tools for the internal medicine preceptor; and more.

The resource kit is available from ASIM for \$10 to cover shipping and handling. Send a check to ASIM Dept KNR, 2011 Pennsylvania Ave, NW, Suite 800, Washington, DC 20006. Or call 202/835-2746, ext 265.

### **Lawsuit Challenging National Data Bank Dismissed**

A Federal Judge in Pennsylvania recently dismissed what may have been the first lawsuit by a physician challenging the constitutionality of the National Practitioner Data Banks' reporting process. The physician challenged the filing of a data bank report that contained information which predated the data banks' creation.

The court determined that the federal Health Quality Improvement Act of 1986, under which the physician sought judgment, did not create a private right of action. The court also rejected the physician's charges of federal civil rights violations.

The physician has indicated that he will appeal this matter to the US Supreme Court if necessary. KMA will monitor this case through the court system and report any significant rulings at a future date.

### **HCFA to Publish Notices of Section 1115 Waiver Requests**

HCFA has announced the monthly publication of a notice in the Federal Register of all new and pending

proposals for Medicaid demonstration projects submitted by states to Health and Human Services for public comment.

Under Section 1115 of the Social Security Act, HCFA has the authority to grant states waivers from certain statutory and regulatory Medicaid requirements. HCFA will not take any action on the proposals for at least 30 days after publication in the Federal Register.

KMA will monitor these monthly publications to determine if Kentucky Medicaid officials are seeking approval for any waivers. This new process will also allow KMA and other interested parties input prior to HCFA review.

### **PRO Cooperative Cardiovascular Project — (CCP)**

The Chairman of the KMA PRO Advisory Committee, **William H. Mitchell, MD**, has learned that in early 1995, the Kentucky Medical Review Organization, the Professional Review Organization (PRO) for the state, implemented a study to evaluate the quality of care for Medicare beneficiaries admitted with Acute Myocardial Infarction (AMI).

This study will be measuring quality of care and improving quality of care.

There are 12 quality indicators in the CCP. Seven of the indicators focus on treatment for the patient at the time of presentation to the hospital. These include confirmation of AMI, use of thrombolytes, timing of thrombolytes, use of aspirin during hospitalization, timing of aspirin during hospitalization, use of heparin, and use of nitroglycerin.

Five of the indicators focus on treatment of the patient at discharge. These include use of aspirin at discharge, use of beta blockers, use of ACE inhibitors, avoidance of calcium blockers with low LVEF, and smoking cessation counseling.



We encourage Kentucky physicians to continue their careful documentations of these elements of care for patients with Acute Myocardial Infarction.

### Prescription Dosage Instructions

The Kentucky Pharmacists Association is seeking support in ensuring proper dosage instructions are included on all prescriptions. With the passage of OBRA 1990 and subsequent Kentucky Board of Pharmacy Administrative Regulations, the pharmacist's responsibility to counsel patients regarding medications prescribed for them has increased and the KPhA requests that physicians avoid using instructions such as "take as directed."

Writing more specific dosage instructions will enhance patient care and assist pharmacists in providing appropriate patient counseling.

### Mediscope

Initial editions of *Mediscope*, a quarterly newsletter directed to patients, have been well received. The newsletter, sponsored by the KMA Public Education Committee, is designed to serve multiple purposes. Each edition communicates the position of physicians on at least two "issues" of concern to the medical profession; features a representative of the profession who has made a significant contribution to the community; and contains articles intended to attract casual readers, thus extending the exposure of our message.

Each KMA member is provided 10 copies of each issue of *Mediscope*. Many physicians are ordering additional copies. Feedback from physicians statewide indicate the copies quickly disappear when they are made accessible to patients. That is one of our goals — to have patients

find the newsletter interesting enough to want to take it home with them. Additional copies are available at \$15 per hundred plus postage. If you would like to contribute an article to *Mediscope* or order additional copies, you may contact the KMA office at 502/426-6200.

### Free Packet Covers Immunization Guidelines

The American Medical Association, working with the Centers for Disease Control and Prevention, has developed an educational packet on immunizations that is now available to physicians. The packet, titled "Make Sure They're Covered," contains information on the following:

- the Vaccines for Children program;
- the updated recommended immunization schedule;
- Standards for Pediatric Immunization Practices;
- vaccines in development;
- vaccines for older adults;
- vaccines for immunocompromised patients; and
- the National Vaccine Injury Compensation Program.

Also included are the CDC "Guide to Contraindications to Childhood Vaccinations" and additional references and useful phone numbers. The project's expenses are funded through a grant from the CDC.

The kits are available free by calling 1-800/621-8335 and requesting product number NCO15895. The information kit includes a toll-free number for follow-up calls.

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1985, Duke

**Gordon J. Settlow, MD** — PTH  
2501 S Virginia St #12, Hopkinsville 42240  
1970, U of Louisville

#### Daviess

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2816 Veach Rd, Owensboro 42303  
1988, Ohio State

#### Fayette

**Velma V. Taormina, MD** — OBG  
513 Ridgewater Ct, Lexington 40515  
1990, Texas Tech

**Benjamin C. Warf, MD** — NS  
2228 Bonhaven Rd, Lexington 40515  
1984, Harvard

#### Hardin

**Prabodh M. Mehta, MD** — C  
606 Foxfire Rd, Elizabethtown 42701  
1977, GS Med Coll Bombay

#### Harlan

**Mary P. Fitzgerald, MD** — OBG  
2901 N Highway 413, Baxter 40806  
1989, Univ Coll Dublin Ireland

**Stanley W. Pletcher, MD** — OPH  
37 Ballpark Rd, Harlan 40831  
1990, Indiana

#### Jefferson

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7340 E Pennington, Lanesville IN 47136  
1987, U of Florida

**Paul Andrews, PhD**  
225 Executive Park, Louisville 40206

**Cynthia E. Gonzales, MD** — PD  
PO Box 22252, Louisville 40252  
1981, U of Philippines

**Fadi A. Khawli, MD** — IM  
2306 Emerson Ave, Louisville 40205  
1986, American U of Beirut

**Charles M. Maxfield, MD** — R  
12300 Ridge Rd, Anchorage 40223  
1988, Dartmouth

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250 E Liberty #902  
1985, U of Kentucky

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3301 Audubon Ridge Dr, Louisville  
40213  
1990, Ohio

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210 E Gray #706, Louisville 40202  
1988, U of Louisville

**Siraj U. Siddiqi, MD** — IM  
850 Washburn Ave #224, Louisville  
40222  
1990, Marshall

**Miodrag Stikovac, MD** — C  
9717 Grandin Woods Rd, Louisville  
40299  
1978, U of Zagreb Yugoslavia

**Robert D. Williams, MD** — OPH  
1169 Eastern Pkwy #3334, Louisville  
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1975, Duke

**Jeuti B. Wylde, MD** — P  
3308 Nanz Ave, Louisville 40207  
1979, Gauhati Med Coll Assam

**Johnson**

**Thomas A. Smith** — FP  
713 W Broadway Ave, Paintsville  
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1985, Emory

**Northern Kentucky**

**David C. Randolph, MD** — PM

4777 Red Bank Crossway #1,  
Cincinnati OH 45227  
1975, Ohio State

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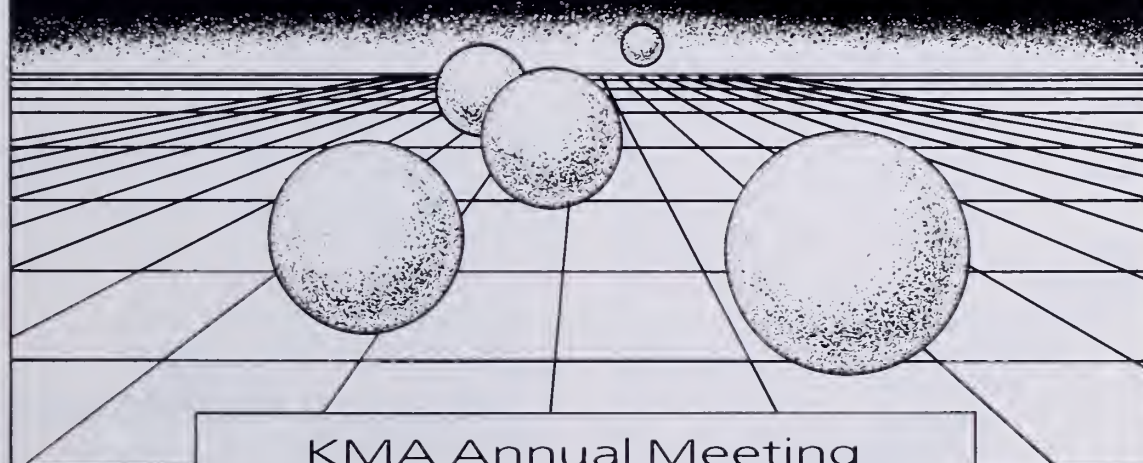
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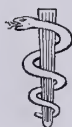
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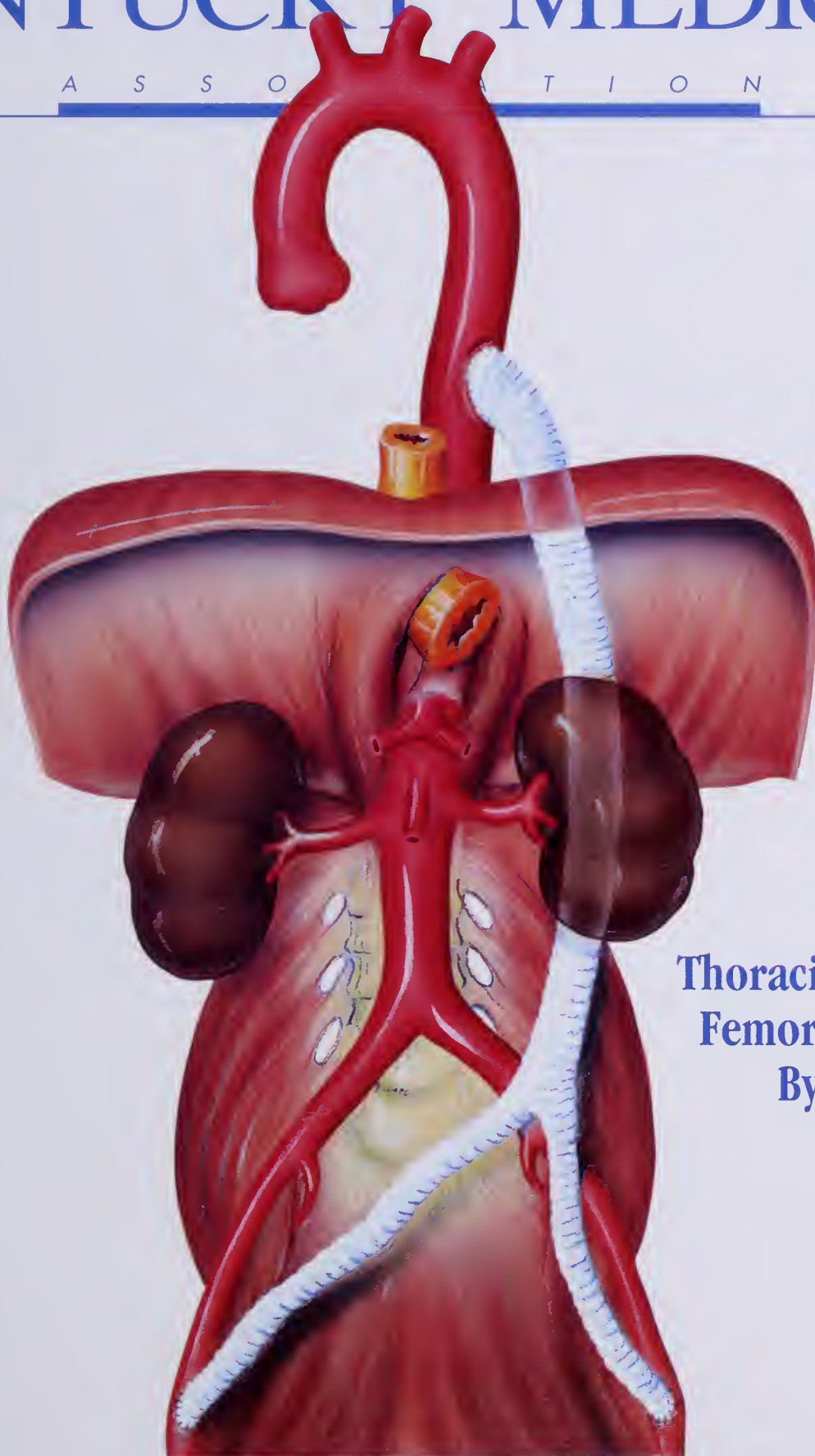
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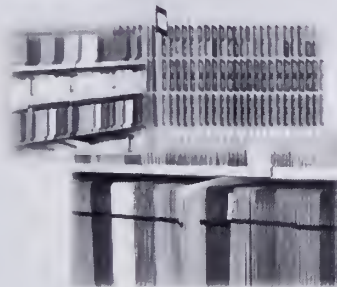


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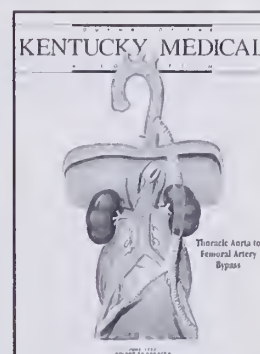


JOURNAL OF THE  
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VOLUME 93, NUMBER 6

JUNE 1995

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Artwork by Lee Wade of Louisville.

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It has the same organizational structure as Congress. Representatives — physicians that you know and work beside — are elected — by you — and sent to be your voice with other physicians. Like you, these representatives come from all walks of medical life with all of its myriad interest. The policies the AMA adopts may not always satisfy all individuals, but these policies represent a consensus of well intended outlooks — like yours.

The AMA represents all physicians. It is not an internist or a surgeon organization. It is not a fee-for-service or a managed care organization. It is not an academic or practicing physician organization. The AMA is all this and more.

Why, then, do less than fifty percent of the physicians in the

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The AMA is the future of medicine, its your future. Were it not for the AMA, all the different medical practice situations and interests we all espouse wouldn't exist. The art and science of medicine would be dictated by the fiat of politics, bureaucracy, or social whimsy.

The AMA does speak for American medicine. If you want to be heard, join the AMA today. Don't take the attitude of letting someone else do it for you. Every physician in America needs to belong to the AMA. I shudder to think of how medicine would be practiced today and in the future if not for the AMA. If you're not a member, join your AMA colleagues now and help shape and preserve our great profession.

**Donald C. Barton, MD**  
Senior Delegate, AMA



*Donald C. Barton, MD*

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## Provider Tax Repeal/Amend HB 250

**S**enator Tim Shaughnessy (D), Louisville, Chairman of the powerful Senate State Government Committee has prefiled legislation (BR 258) to amend or delete major portions of HB 250. Hearings on the proposed legislation are expected during the interim prior to the 1996 Session of the General Assembly.

### SUMMARY OF BR 258

#### Insurance Reforms

Under the definition of health insurer, a technical change is made to reference the criteria that must be met by a provider sponsored integrated health delivery network.

Local governments are removed as mandatory members of the Kentucky Health Purchasing Alliance. This includes elected and salaried employees of cities, counties, urban counties, charter counties, and special districts excluding school districts.

Local government groups are allowed to become voluntary members of the Kentucky Health Purchasing Alliance.

Under the definition of insurer, a technical change is made to reference the criteria that must be met by a provider sponsored integrated health delivery network.

The any willing provider provision is deleted from the law.

The intent of the law is clarified to provide that community rates may be established separately for individuals and employer groups.

The Board is directed to develop an additional number of standard plans so that five plans are in existence.

Provider sponsored integrated health delivery networks must meet the criteria in this section before they can offer health plans in Kentucky. Networks in existence on the effective date of this legislation will have 30 days within which to comply with the standards. Networks must disclose on a form to the commissioner of the Department of Insurance:

- name and address

- names and addresses of all preferred providers in the network
- number of covered persons

Networks must furnish the commissioner evidence of a surety bond, reinsurance or other form of financial resources in the amount of \$1,000,000 if a corporation and \$3,000,000 if a partnership. The information must be updated with the commissioner annually.

#### Medicaid Managed Care

The Cabinet for Human Resources is required to establish a managed care system to provide health services to Medicaid recipients. The system shall consist of one health care partnership (a coalition of providers in the public and private sector) in eight separate geographic regions to be defined by the cabinet. The cabinet would determine a capitation rate for providing services to recipients and contract with the health care partnership to provide services for all Medicaid recipients in the region. Persons with incomes below 200% of the poverty level are authorized to participate if they pay the monthly capitation rate. The partnership would be responsible for contracting with individual providers and determining payment levels to providers based on the amount allotted to serve each recipient. Benefits to be covered include: inpatient and outpatient hospital services; physician services; family planning services; laboratory, x-ray, and diagnostic services; preventive care; home health services; prescription drugs; dental services, and transportation. Specified Medicaid recipients are exempt from participating in the program,



including recipients in institutions, qualified Medicare beneficiaries; and recipients eligible through spend down. The medical schools at the University of Kentucky and the University of Louisville shall serve as an anchor in as many health care partnerships as possible through the provisions of staff, technical support, and tertiary care.

## Discount Option Program

Discount Option Program created in HB 250 is eliminated.

## Long-Term Care Elimination Period

The first 12 months of nursing facility care provided to Medicaid recipients who become eligible after the effective date of this act is excluded from Medicaid coverage.

## Long-Term Care Insurance

The commissioner of the Department of Insurance will certify a long-term care insurance policy if it meets the minimum statutory standards established in the insurance code.

Any person who pays the premiums on a certified long-term insurance policy will qualify for the income tax deduction.

The amount paid for long-term care insurance is authorized to be excluded from income for purposes of state income tax.

## Provider Tax

Two percent tax on the gross revenues for provision of physician services, home health care services, and HMO services is removed. The provider tax is left on hospitals and nursing homes.

## Repealer

The tax of 25 cents per prescription imposed on pharmacies and other providers dispensing or delivering prescription drugs in Kentucky is repealed.

## Effective Dates

The deduction for premiums paid on long-term care insurance will apply to the taxable year beginning after December 31, 1996. This will enable anyone who purchases or renews a policy during 1996 to claim a deduction on their 1996 state income tax return which will be filed in 1997.

The changes to the provider tax will take effect on August 1, 1996.

## Fall Pre-Legislative Conferences

The KMA Public Education Committee has announced that pre-legislative conferences will be conducted in each KMA trustee District beginning in early October and concluding no later than November 15. Conference participants include physicians, spouses, and other interested parties supportive of medicine's efforts. Dates, locations,

and times of meetings will be coordinated with the KMA District Trustee.

Topics include repeal of the physician component of the provider tax; tort reform; amending sections of HB 250; reforming Medicaid; continued inroads by nonphysician practitioners; and other legislative concerns. Political activity will be

highlighted including restructuring of KEMPAC. In addition, enhancing KMA legislative key contacts with additional information and lobbying techniques and establishing local phone banks, use of local mailings, etc, will be important goals of these conferences.

Watch for future mailings with dates, times, and locations in each KMA Trustee District.

## KEMPAC Goals

At its quarterly meeting in April, the KEMPAC Board of Directors approved a restructuring of its goals. KEMPAC Chair William P. VonderHaar, MD, announced the following goals and noted the increase in membership.

- ✓ Support financially those candidates who have demonstrated or indicated a knowledge and understanding of health care, the

health care delivery system, and the physician/patient relationship.

- ✓ Develop a voter registration drive for physicians, physicians' families, and staff immediately through the combined organizations of KEMPAC, Alliance, and KMA.

- ✓ Educate Kentucky physicians regarding the position of each state and national legislator concerning issues of medical importance, voting

records, and general views toward medicine and physicians.

- ✓ Target specific districts through polls, surveys, and other methods to assist in the election or defeat of designated candidates. Focus maximum efforts on winnable races.

- ✓ Emphasize the importance of physicians, their families, and staff of the need to become politically informed and involved.

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# Descending Thoracic Aorta to Femoral Artery Bypass

*Robert O. Mitchell, MD; Stephen B. Self, MD; Roy G. Bowling, MD;  
Gerald D. Temes, MD; James M. Van Daalen, MD*



*Anatomic placement of a synthetic graft from the infrarenal aorta to the iliofemoral vessels has been a long recognized technique used to bypass occlusive disease of the distal aorta and iliofemoral arteries. However, in a few select patients with failure or infection of the abdominal graft, or in patients with a "hostile" abdomen from multiple prior operations, the descending thoracic aorta may be used as an inflow source for the iliofemoral vessels. This paper will discuss the indications, patency data, and technique of descending thoracic aorta to femoral artery bypass with a case presentation.*

The standard surgical treatment for occlusive disease of the terminal aorta or iliac arteries is infrarenal aortobifemoral bypass. However, there are circumstances in which infrarenal aortobifemoral bypass may not be optimal. Such situations include reoperation for failed aortobifemoral grafts and patients with multiple prior abdominal surgeries. Alternative approaches would be useful in these difficult situations. The following case presentation illustrates some of these problems.

#### Case Presentation

The patient is a 52-year-old man who presented with severe claudication and rest pain. Physical exam demonstrated the absence of palpable femoral pulses bilaterally and arteriogram (Fig 1) demonstrated occlusion of the terminal aorta. His past history was remarkable for multiple prior vascular reconstructions and abdominal procedures as outlined below:

- 1980 — Cholecystectomy, common bile duct exploration, pancreatic biopsy.
- 1981 — Exploratory laparotomy and drainage pancreatic pseudocyst.
- 1983 — Exploratory laparotomy for bowel obstruction with perforation, adhesiolysis, resection 6 feet small intestine, gastrostomy tube, and placement abdominal drains.
- 1985 — Iliac artery angioplasty and femoral-femoral bypass.
- 1986 — Exploratory laparotomy, adhesiolysis, repeat common bile duct exploration, duodenotomy, sphincteroplasty of ampulla of Vater and pancreatic duct, choledocho-duodenostomy, repair abdominal wall hernia with marlex.

1986 — Thrombectomy and revision of femoral-femoral bypass.

1988 — Thrombectomy femoral-femoral bypass.

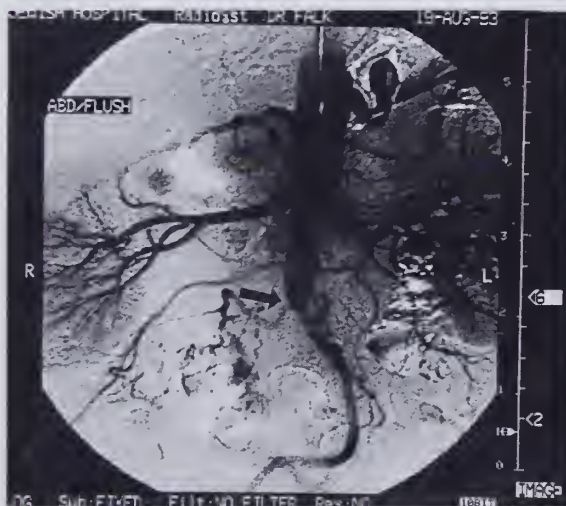
1990 — Redo femoral-femoral bypass.

1993 — Thoracic aorta to femoral artery bypass.

#### Surgical Technique

The patient is positioned with the left hemithorax at 45 degrees and the pelvis flat to allow access to both groins. A double-lumen endotracheal tube allows for collapse of the left lung and better exposure of the thoracic aorta. Standard groin incisions are performed as is a limited left anterolateral thoracotomy through the seventh interspace. Rib resection is not needed. The inferior pulmonary ligament is divided and the pleural covering of the descending thoracic aorta is incised. A counter-incision in the left flank facilitates tunneling of the graft from the chest to the left retroperitoneal space. The four incisions are depicted in Fig 2. A small incision is made in the left posterior diaphragm and blunt dissection creates the tunnel in the retroperitoneum posterior to the spleen and kidney. After systemic heparinization, a partial occluding clamp is placed on the distal thoracic aorta. A bifurcated graft is anastomosed to the thoracic aorta in an end-to-side fashion (Fig 3). Each of the femoral limbs of the bifurcated graft are anastomosed to their respective femoral arteries.

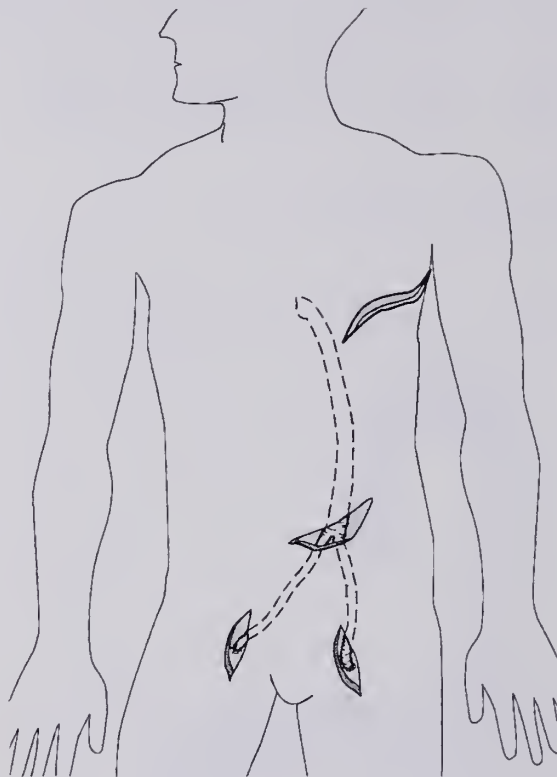
*From the Department of Surgery, University of Louisville School of Medicine, Louisville, KY 40292, and the Jewish Hospital Heart and Lung Institute, Louisville, KY 40202.*



**Fig 1 — Aortogram demonstrating occlusion of terminal aorta and iliac vessels (arrow).**



## Thoracic Aorta to Femoral Artery Bypass



**Fig 2** — Incisions used for bypass from the thoracic aorta to the femoral arteries. There are 2 standard groin incisions, a left flank counterincision, and a left thoracotomy incision.



**Fig 3** — End-to-side anastomosis (arrow) of dacron graft (Gft) to thoracic aorta (Ao). The lung (Lg) is retracted medially.

## Discussion

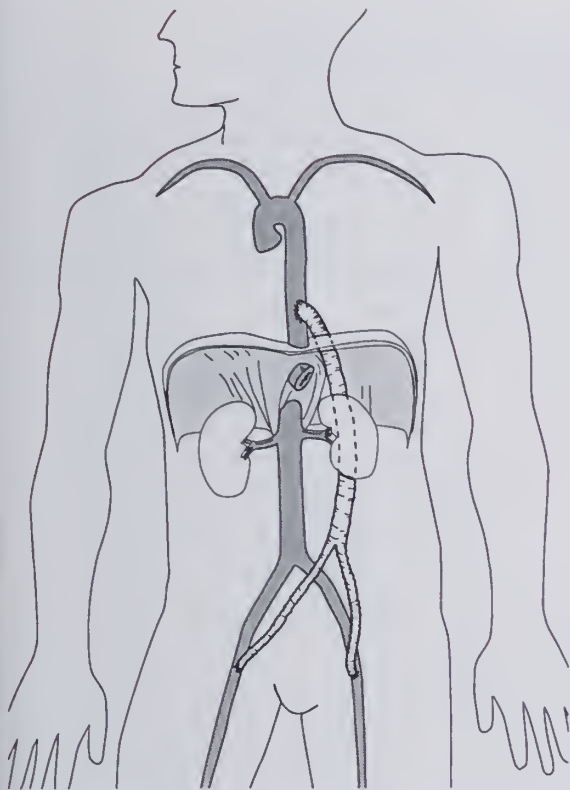
The “gold standard” in aortoiliac reconstruction for occlusive disease has been the infrarenal aortobifemoral bypass. The patency of these grafts range from 83% to 92% at 5 years and 71% to 83% at 10 years.<sup>1,2</sup> These patency rates are acceptable and the majority of grafts are patent for the lifetime of the patient. However, graft failure will develop in 6% to 13% of these patients in their lifetime.<sup>23</sup> Graft failure is usually the result of progressive atherosclerotic disease of aortic inflow or infrainguinal outflow. Another cause of graft failure is infection. Reoperative surgery for graft failure has not been as promising. Repeat infrarenal aortofemoral bypass carries a reported operative mortality of 7% to 14% and an early amputation rate of 6% to 14%.<sup>3,4</sup>

Replacement of failed or infected aortofemoral grafts by axillofemoral extra-anatomic bypass has also been disappointing with operative mortality reported at 2% to 13% and primary patency reported at 19% to 47% at 5 years.<sup>5,6</sup> Despite these unfavorable statistics, axillofemoral bypass has remained the favored technique after a failed and/or infected aortofemoral bypass.

Another source of inflow to the femoral arteries can be the descending thoracic aorta (Fig 4). Bypass from the thoracic aorta to the femoral arteries was first performed by Lester Sauvage in 1956.<sup>7</sup> Since that time, only 166 similar cases have been reported in the literature, despite favorable outcomes in terms of mortality and graft patency in nearly all published series.<sup>8,11</sup>

The general indications for using the thoracic aorta include patients with an infected abdominal aorta graft, multiple failures of infrarenal aortic grafts, and patients with a “hostile” abdomen from multiple previous abdominal surgeries or irradiation. Use of the thoracic aorta is especially appealing in younger patients in whom an axillofemoral bypass, with its poor patency rates, might be expected to fail a number of times during the patient’s lifetime.

Of the 166 reported cases of thoracic aorta to femoral bypass, there was a perioperative mortality of 6.6% (11 patients).<sup>8</sup> A recent series reported a 10-year experience with 21 of these procedures. There were no perioperative deaths during a follow-up period of 1 to 121 months (mean 44). The primary graft patency was 100% at 4 years. One graft failed at 49 months but was salvaged by thrombectomy to produce a secondary patency rate of 100% among all grafts.<sup>8</sup> Seven-



**Fig 4 — Illustration of descending thoracic aorta to bifemoral bypass.**

teen of the 21 procedures represented the patient's second or third attempt at revascularization. This represents an improvement in perioperative mortality when compared with reoperative infrarenal aortofemoral bypass as discussed earlier. In the case presented, we felt an infrarenal aortobifemoral graft would be difficult by the transabdominal approach. Even with an abdominal retroperitoneal approach, it might be difficult to safely expose and control the infrarenal aorta in a patient with multiple episodes of pancreatitis. Additionally, an axillofemoral bypass was considered a possible option, but the poor patency rates of these grafts argue against their use in a younger patient. We performed a descending thoracic

aorta to bifemoral bypass. The patient was extubated in the recovery room and discharged on postoperative day 13 with palpable pedal pulses. At follow-up 3 months postoperatively, the patient was ambulatory without claudication.

Descending thoracic aorta to femoral bypass is not the procedure of choice to treat uncomplicated aortoiliac occlusive disease. However, in a few select patients with complicated surgical histories, this procedure should be considered as an option.

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## 1995

## JULY

**12-16 — Internal Medicine Board Review, Radisson Plaza Hotel, Lexington, KY.** Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

## OCTOBER

**7 — 12th Annual Ophthalmology Seminar: Management of Diabetic Retinopathy by the Comprehensive Ophthalmologist. Audubon Regional Medical Center, Louisville, KY.** Contact: Cathy Edens, 240 Audubon Medical Plaza, Louisville, KY 40217; 502/636-2823.

**6-17 — Allergy Abroad '95, The Ritz-Carlton Hotel, St. Louis, MO. Sponsored by Washington University School of Medicine.** Contact: CME Office, Washington University School of Medicine, Campus Box 8063, 660 South Euclid Ave, St. Louis, MO 63110-1093; 314/362-6893; 800/325-9862.

## NOVEMBER

**5-10 — 26th Family Medicine and Primary Care Review — Session III, Hyatt Regency Hotel, Lexington, KY.** Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

**17-18 — Perinatal/Neonatal Symposium, Radisson Plaza Hotel, Lexington, KY.** Contact: Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

## 1996

## JANUARY

**28-February 3 — Practical Aspects of Diagnostic Radiology/Medical Imaging, Silvertree Hotel, Snowmass Village, CO,** sponsored by Vanderbilt University Medical Center. Contact: Marilyn J. D'Asaro, Manager/Program Coordinator, Div of CME, Vanderbilt University School of Medicine, D-8211 Medical Center North, Nashville, TN 37232-2337; phone — 615/322-4030.

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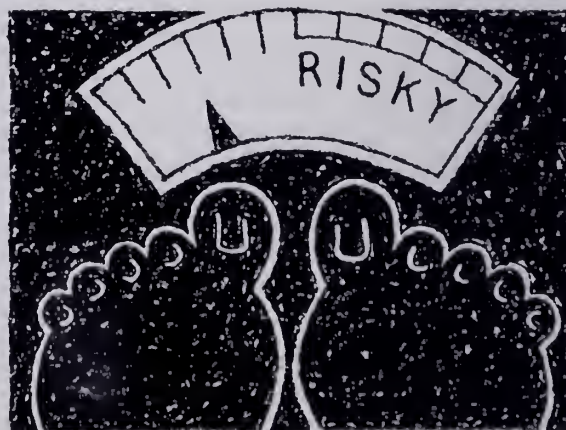
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# An Exploratory Study of the Experiences of Rural Women with Breast Cancer

F. Wesley Dunaway, BS; William J. Hueston, MD; Lana Clevinger, MSW

*Patient adjustment to chronic illness is influenced by various cultural factors. This study examined some of the issues faced by rural patients in adjusting to the diagnosis of breast cancer.*

*A sample of 10 women who had been diagnosed with breast cancer from 12-36 months prior to the study were recruited from a variety of sources. Using a long-interview qualitative research format, each patient was questioned about her reactions to her illness and relationship with medical providers. Interviews were tape recorded and the texts were transcribed and analyzed using an editing-analysis format with a multidisciplinary analysis team.*

*As might be expected, patient reactions to their illness and health care providers varied considerably. Notable findings were a sense of urgency for treatment after diagnosis and a general sense of dissatisfaction with patient-physician communications.*

*This group of rural women with a life-threatening cancer expressed a greater need for information and collaborative decision making than was met by their oncologists. Further exploration of this hypothesis would be helpful to determine how prevalent these opinions are among rural patients.*

Dealing with chronic illness can be difficult for patients and physicians. When the illness is life threatening, these difficulties may be multiplied. Although other studies suggest that most patients are satisfied with their overall relationship with their physician,<sup>1</sup> patients and physicians frequently disagree on the patient's needs and perceptions of their disease.<sup>2</sup>

These divergent views may lead to misunderstandings and conflicts during management of the patient's illness and undermine the therapeutic

relationship between patient and provider.

The unexpectedness of cancer causes a wide array of emotions in patients.<sup>3</sup> Many of these emotions may cloud the physician-patient relationship and, if unrelieved, may be predictors of a poor prognosis.<sup>4</sup> To facilitate the therapeutic relationship, physicians must recognize not only the physical problems associated with a chronic illness such as cancer, but must address these psychological problems as well.<sup>5</sup>

Several patients approach the diagnosis of cancer with an "information seeking" coping style while other patients adopt an "information avoidance" style.<sup>6</sup> Cultural issues may influence patients' adjustment to their illness. For example, patients from rural areas tend to avoid cancer screening primarily due to a fear of what might be known.<sup>7,8</sup> The suggestion that rural patients are more fearful of information suggests that patients with this cultural background may be more comfortable with an information avoidance coping strategy. However, there is little evidence evaluating rural patients' coping styles and satisfaction with information communicated during medical encounters.

To evaluate the range of patient responses to the diagnosis and initial management of cancer, we performed a qualitative study of the reactions of women with breast cancer. Because physicians often misjudge which issues are important to their patients,<sup>8</sup> knowing the range of potential responses from patients with rural backgrounds might be helpful in anticipating the needs of women diagnosed with breast cancer. The intent of this study was to identify a spectrum of emotional responses of patients so that physicians could anticipate the possible psychological reactions of their patients and forge better physician-patient relationships.

*From the University of Louisville School of Medicine (Mr Dunaway), St. Claire Medical Center, Marehead (Dr Hueston), and the Kentucky Cancer Program, Marehead (Ms Clevinger). At the time of this study Mr Dunaway was a second year medical student at the University of Louisville.*



## Rural Women with Breast Cancer

## Methods

Since this study was viewed as a hypothesis-generating project which aimed to gauge the range of emotions and reactions of patients, a qualitative methodology was chosen to explore the breadth of possible reactions from a divergent sample of women. To accomplish this, a sample of 10 women with widely divergent backgrounds who lived in a five county area of rural northeastern Kentucky and who had been diagnosed with breast cancer were recruited through a network of support groups, physicians, and home assistance groups.

The rural area from which the sample was chosen has a total population of approximately 68,000, with 34,500 women. The area is served by three acute care hospitals with additional tertiary referral available 30 to 60 miles away.

To minimize recall error, subjects were chosen who had completed treatment 12 to 24 months prior to the start of the study. Subjects also were purposely chosen to represent a wide diversity of possible experiences based on varying demographic and medical backgrounds (Table 1).<sup>9</sup> Factors that were considered when recruiting patients included age, type of treatment received, employment history, and education level. The sample size was determined from an initial estimation that 12-20 women would be required before the themes generated were highly redundant<sup>10</sup>; however, redundancy in themes occurred after only 10 interviews.

Interviews were performed using a semi-structured long interview format.<sup>11</sup> Interviews lasted 30 to 60 minutes and were performed by a medical student who had taken a course on

medical interviewing. Interviews were conducted wherever it was most convenient for the subject and were tape recorded. The interviewer kept field notes which summarized nonverbal responses of each patient; these notes were included with transcripts of the interview for analysis.

Data analysis was performed using an editing-analysis methodology<sup>12</sup> by a data analysis panel consisting of a family physician, social worker, nurse practitioner with previous oncologic nursing experience, and the interviewer. Each member of the panel read the text individually and identified key phrases which were synthesized into themes for each subject. The themes from individual interviews were collected and discussed by the analysis panel. When disagreement arose over particular themes, the themes were discussed until a consensus was reached among members of the panel.

## Results

Interviews focused on two general areas: women's initial reactions to their diagnosis and treatment, and women's experiences with their health care providers. Important themes from the analysis of these interviews are presented below and in Table 2.

*Initial Reactions to Diagnosis and Treatment*

Despite the fact that some women suspected that they had breast cancer, feelings of *shock*, *disbelief*, and *resentment* predominated when the diagnosis was made. Several women reported being fearful of the unknown. However, as illustrated by the following patient, even those who had a

Table 1. Profile of Study Participants

Sub	Age	Occupation	Marital Status	Education	Therapy*
1	38	Administrator	Married	College	S
2	72	Retired	Widowed	<High School	S
3	68	Kitchen Worker	Married	High School	S
4	45	Bank Teller	Married	High School	S+C
5	49	Nurse	Divorced	College	S
6	46	Teacher	Married	Master's	S+C+R
7	45	Secretary	Married	Some College	S
8	70	Consultant	Married	PhD	S+C
9	49	Health Aide	Married	2 Yr College	S+C+R
10	62	Retired	Married	High School	S+C+R

\* S = surgery; C = chemotherapy; R = radiation.

**Table 2.** Important themes generated in the study.

<i>Important themes regarding diagnosis.</i>
Fear and shock
Resentment that problem was not discovered earlier
Problems with employment
Altered body image
Early support from other women with breast cancer
<i>Important themes regarding treatment</i>
Control
Quality of patient-physician communication
Location of treatment

good understanding of breast cancer and upcoming treatment and prognosis were afraid:

*"I sure was well informed, but that didn't keep me from feeling scared."*

Among the feelings not shared with their medical caretakers, some women harbored resentment that their disease was not discovered earlier because they had the sensation that something was wrong with them, but did not feel they were taken seriously by their physician. One patient who felt this way remarked that she believed women tend to hesitate in trusting their "gut" feelings about breast cancer because they do not wish to be accused of imagining a problem. Another patient summarized her experience with diagnosis as follows:

*"I was disappointed that they didn't find it before and they didn't listen to what I was trying to tell them about it."*

Once the diagnosis of breast cancer had been made, most women described an initial sense of urgency that treatment begin as soon as possible. For some, this reflected a sense of loss of control over their body and a belief that prompt treatment would restore this control.

Many women also raised other issues which were important to them during the period of diagnosis and treatment. Many women who were employed at the time of their diagnosis felt that it was beneficial to their recovery that they returned to work. However, another patient who was employed felt that she had been pressured to return to work too quickly. Many of the women who were employed expressed dissatisfaction about their employer's lack of understanding of their

problem and unrealistic expectations for them upon returning to work. As one patient suggested:

*"I think employers should be educated (about breast cancer), especially those who employ lots of women. I think doctors should go to the senior management and tell them 'this is what can be expected.'"*

Despite some problems with employment, most women wanted to continue to work during treatment. The desire to work appeared to be strongest in women who valued staying active and avoiding being a burden to their family.

As might be anticipated, another important issue for some women during diagnosis and treatment was their altered *body image*. As one patient remarked:

*"I was horrible looking, I felt sorry for myself. I thought I was a freak and felt like a horrible looking creature."*

This concern was not shared by all women, but those who expressed these feelings felt very strongly that these feelings should be addressed early in the course of therapy.

Issues relating to *support from other women with breast cancer* were also raised. In general, women appreciated speaking to someone else who had breast cancer, but many suggested that this contact be initiated before surgery rather than afterwards. As one individual said,

*"You need to see someone (before surgery) who has been through it and that they look and feel normal. They wait until after the fact and it's before the fact that you need more support."*

#### *Experiences with health care providers and medical system*

In general, women who felt that breast cancer caused them to lose *control* of their lives generally reported negative experiences with treatment. Women who felt that they retained control and were allowed to participate in their treatment decision reported better experiences.

Many women expressed anger about the overall approach to cancer therapy. In the words of one subject:

*"I thought that oncology had definitely succeeded in coming to a point where they know how to destroy. I know they can make you sick; they've accomplished that. I know they can kill healthy cells and I'm assuming they*



## Rural Women with Breast Cancer

*can kill cancer in the process. But it didn't seem to me that much has been done with restoring. It was just sort of left to your body to recover from this. I thought somehow or another the medical profession needs to go a step further."*

The biggest issue for women was the *quality of their communication* with their providers. Poor communication with their physician was one of the most frequent complaints about women's relationships with their caregivers. Women wanted honesty, compassion, and a sense that their physicians appreciated them for their individuality, a trait that several women summarized as "treating me like a human being." One patient illustrates below the importance of individuality.

*"I went to this one doctor . . . and he said, 'you're just like all other women.' I didn't like that one bit because I was hurting and he made that remark. I won't go back to him anymore; I just didn't like his attitude."*

On the other hand, those women who stated that their physicians listened to their problems and took more time to speak to them were more satisfied with their patient-physician relationship.

In addition, many women remarked about how the *location of treatment* affected them. Some women received their treatment at a local treatment center while others traveled to a university center for their therapy. Women who received their care locally generally expressed more positive feelings toward their caregivers than those who had sought care in a tertiary setting. Some women remarked that the local doctors seemed to have a "common touch," while those at the university appeared to be preoccupied and less approachable. The statements from two women who received their care in different settings illustrate this finding:

*"The university oncologist was nice, but he was scattered. His mind was elsewhere. I think he was too much into research to really be able to come down to my level and talk to me."*

*"My doctor's like the average old Joe and I think he is really smart. He does not use those big medical terms that's beyond your head. He just sits down and talks on your level. He really cares and it's not a put-on. He doesn't appear like most doctors, just as common and friendly as can be and yet he is very intelligent."*

## Discussion

Patients with chronic diseases such as breast cancer react in a wide variety of ways. Other studies have suggested that rural patients use different mechanisms for dealing with illness or potential illness than do urban patients.<sup>6,8</sup> While previous information suggested that rural residents generally adopt information avoidance as a strategy for coping with medical problems,<sup>6</sup> the stories told by these patients appear to contradict this generalization. In this small group of women with breast cancer, the most common themes were those of loss of control and lack of communication with their health provider.

These findings suggest that many rural women experiencing breast cancer do not react differently from women from more urban backgrounds. Providers should be aware that patients from similar demographic or ethnic backgrounds may present with a diversity of coping styles and that the provider-patient interaction must be tailored to meet the needs of the individual patient.

Additionally, physicians should be cognizant of the psychosocial issues faced by patients when diagnosed with a chronic illness and understand that different patients may have differing needs and expectations.<sup>13</sup> Women in this study expressed a range of responses to their illness and varying expectations from their caregivers. Of most concern is that women in this study were dissatisfied when they were not included in the decision-making process underlying their medical care.

Women from rural cultures wished to be included in the planning, and decision-making for therapy appears to be beneficial since it may result in returning a greater degree of control of the situation to the patient, which is consistent with other studies of patients with chronic health problems.<sup>3,14</sup> Giving women control over therapeutic options may improve satisfaction with treatment and may help patients adjust to rehabilitation following breast cancer surgery.<sup>3</sup> None of the women in this study wished to avoid information about their problems; rather, when women sensed that information was being withheld, they strongly criticized their providers.

Some women in this study also entered in their patient-provider relationship with feelings of resentment over their previous care. Physicians treating patients with cancer should be aware that some patients harbor these feelings. When these feelings are present, physicians should attempt to

recognize these issues and attempt to resolve them early to foster an honest and healthy relationship.

While the findings from this study may be useful in discovering potential issues that may be important to women diagnosed with breast cancer who reside in rural areas, the qualitative nature of the methodology does not allow us to state how prevalent these feelings are or allow analysis based on possible predictive factors such as demographics, socioeconomic status, or educational background. Instead, the intent of this study was to explore the range of issues confronting women from rural backgrounds who are diagnosed with cancer.


In summary, patients in this study identified several important factors which influenced the course of their illness. To provide the best care to each individual patient, physicians should be aware that a wide spectrum of emotional responses occur during life-threatening, chronic illnesses such as breast cancer. Attention to these emotional issues may improve physician-patient education and result in greater satisfaction with care for both patient and health care provider.

**ACKNOWLEDGMENTS:** This project was supported by funds from the MECO Program at the University of Louisville and by the Kentucky Cancer Program, University of Kentucky. The authors would also like to thank Julia Kern, RN, ARNP, for assisting with data analysis and Carolyn Plank for preparing the transcripts from patient interviews.

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# Physicians for the 21st Century: Implications for Medical Practice, Undergraduate Preparation, and Medical Education

Carol L. Elam, EdD; H. David Wilson, MD;  
Emery A. Wilson, MD; Richard Schwartz, MD

*Changes in medical education and the practice of medicine have resulted from the push for both education and health care reforms. Undergraduates planning application to medical school should broaden their preparation to include communications, computers, economics, and multicultural educational experiences. To prepare graduates for medical practice in the new millennium, the University of Kentucky College of Medicine has implemented a new curriculum focusing on integration of basic and clinical sciences, primary care in ambulatory sites, health promotion and disease prevention, and attention to the ethical, social, psychologic, and financial impact of disease upon the patient, family, and society.*

As we look forward 5 years to the advent of a new century, it is clear that changes in diagnostic and therapeutic technologies, growth of the biomedical knowledge base, and consumer and political forces seeking health care reform are influencing the practice of medicine. These same forces have repercussions in medical education. Yet the impact of such changes may not have been adequately conveyed to undergraduates since many potential medical school applicants continue to receive conventional counseling regarding preparation for medical school. At the biennial meeting of Kentucky's pre-medical advisors, we assembled a panel to discuss changes in medical education and the practice of medicine which have resulted from the push for both educational and health care reforms.

As in the past, the doctor of the 21st century must promote health, prevent and treat disease, and rehabilitate the disabled in a compassionate, ethical way. Increasingly, they must do this within resource constraints. However, physicians for the new millennium must also be better providers of primary care; communicators and critical thinkers; motivated life-long learners; information specialists; practitioners of applied economics, sociology, anthropology, epidemiology and behavioral medicine; health team managers; and advocates for individuals and communities.<sup>1</sup>

Given this description of the 21st century physician, we sought to answer three questions:

1. What impact will health care reform initiatives and biomedical research have on medical practice?
2. How can undergraduate students be best prepared for medical school?
3. What modifications and fundamental changes are being made in the content and nature of medical education?

## Health Care Reform, Biomedical Research, and Medical Practice

America boasts of having the best medical education in the world, the best medical research in the world, and the best health care in the world. While health care reformers seek to maintain quality in education, research, and health care, their reform focus is on reducing health care costs, providing universal access and universal coverage, and better educating the American public regarding health promotion and disease

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## Physicians for the 21st Century

prevention. Health care reform will result in two major changes in health care delivery. First, there will be a shift in the financial risk from companies to providers. Whereas companies or individuals are currently responsible for making health care payments in the form of insurance premiums, the financial risk of health care will be shifted to physicians and hospitals in order to control costs. Instead of paying insurance premiums which increase every year because of the increased costs of individual health care services (fee for service), physicians and hospitals will be paid a set fee for each patient (capitation), and these providers will have to manage the care of these patients (managed care) within that cost structure.

The second major change that will result from health care reform is a shift from providing optimum care for individual patients to providing care for populations of patients. Instead of focusing on each individual patient's problem, doing whatever is necessary to diagnose and treat an illness, the system will concentrate on providing care for populations or groups of patients in an effort to keep them healthy. As a result, there will be a shift from acute care to preventive care, from hospital care to ambulatory care, and from specialty care to primary care. Physicians will be charged to document standards of care for all patients.

Physicians expect changes in their individual practices of medicine as a result of health care reform. Anticipating less autonomy, physicians fear they may no longer be able to run their own practices, set fees for services, or simply be their own bosses. More importantly, they perceive that health care reform will threaten the doctor-patient relationship. Such fears are well founded as while all health care reform plans state that patient choice of physician will be maintained, this is unlikely because of prohibitive costs. Health care reform effects are not restricted to physicians in private practice. Physicians employed in medical schools also are braced for negative impacts of health care reform. Much of the clinical income academic physicians earn goes to support medical education and the research enterprise in academic health centers. If clinical revenues decrease, who will maintain medical education at the level we now enjoy — which makes it the best in the world?

Although health reform will bring changes in the practice of medicine, developments in biotechnology resulting from unprecedented bioscientific research breakthroughs will dramati-

cally alter the diagnostic and therapeutic aspects of medicine. The Human Genome Project, sponsored by the National Institutes of Health, has the goal of identifying all human genes and describing their functions by the year 2005. Whereas medicine is now studied at the organic level — the kidney, the heart, or the lung — medicine in the 21st century will be directed at the subcellular or molecular level. Through various forms of genetic diagnosis or gene therapy, physicians will be able to detect diseases before they actually become symptomatic and be able to cure diseases before they actually occur. Besides gene therapy, a second major advance in 21st century medicine will be transplantation. While hearts, lungs, livers, and a number of other organs or body parts are commonly transplanted today, the key to even greater success in transplantation lies in the prevention of the body's natural rejection of foreign tissues. Researchers are working toward developing more inert substances to transplant (joints, etc) as well as better ways to suppress or prevent the immune system from rejecting transplanted organs.

Because of the rapid expansion of scientific knowledge, tomorrow's physician must have a greater appreciation for lifelong learning. Massive amounts of new medical information being reported annually must be assimilated in order to glean the basic clinical information. The 21st century physician must possess the skills necessary to access information vital to providing high quality care in the future. As a result, they must be computer literate in accessing library resources such as "Lonesome Doc" and "Grateful Med" and must avail themselves of new technologies such as telecommunications to enhance their abilities to provide optimal care.

Apart from the outlined changes in health care delivery anticipated from health care reform and the changing nature in diagnostic and therapeutic modalities resulting from the rapid expansion of knowledge in biotechnology, there is one thing that will not change in medicine — the responsibility for and the caring about the well-being of others. Physicians must be able to demonstrate competence and caring in all contacts with patients and their families — a major factor in support and healing. In an era of increasingly culturally diverse populations, physicians must maintain their abilities to communicate clearly, concisely, and with care both in interpersonal interactions and in written records. Physicians will likely need to guard against depersonaliza-

tion, both of themselves and their patients, as technology leads them down new paths.

In anticipation of the changes coming during the next decade and beyond, how should those aspiring to become physicians for the 21st century be prepared and educated, both as undergraduates and as medical students?

### **Preparation for Medical School**

From the previous projection of medical practice in the early years of the 21st century, it is clear that physicians-in-training must have an understanding of economics and health administration; epidemiology and biostatistics; molecular biology, genetics, and immunology; computer systems and information management technologies; and psychology and sociology in a culturally diverse society. Given the continuum between undergraduate preparation and medical school, it is necessary to gain a foundation for the study of these disciplines in college. Naturally, students will need to arrive at medical school not only with a solid science background but with other knowledge and skills, such as communication, ethics and logic, computer literacy, and social and humanistic knowledge as well.

Students will increasingly need to know how to locate and evaluate information and synthesize data to solve problems. To that end, they should develop computer skills necessary to access the scientific literature. Importantly, undergraduate students must seek educational experiences which force them to move beyond memorization of discrete facts into the more advanced skills of integration, analysis, and application of knowledge to formulate hypotheses. They should develop the skills necessary to assess and remediate their own knowledge. In addition, because medical education is increasingly moving from the passive mode of lecture to the active mode of discourse and problem solving, undergraduate students should seek opportunities to work in small study groups.

Most medical schools require that applicants complete a core of science course work. Minimum requirements generally include a year of biology, general chemistry, organic chemistry, and physics; all with laboratory experiences. Most medical schools also require a year of English, composition, or speech in encouraging development of written and spoken communication skills. The traditional premedical preparation recommended at most undergraduate institutions

continues to emphasize an extensive curricular exposure to the sciences. In fact, over 60% of applicants come from biology or chemistry majors.<sup>2</sup> Although admission guidelines both at the institutional and national levels may stress the value of liberal arts, undergraduate emphasis on the sciences is in large measure driven by admission decisions at medical schools which seem to favor science-trained applicants.<sup>3</sup> Given that physicians of the 21st century should have an understanding of many fields beyond the sciences, it is incumbent upon admission committees to look more favorably on applicants with broad liberal arts backgrounds.

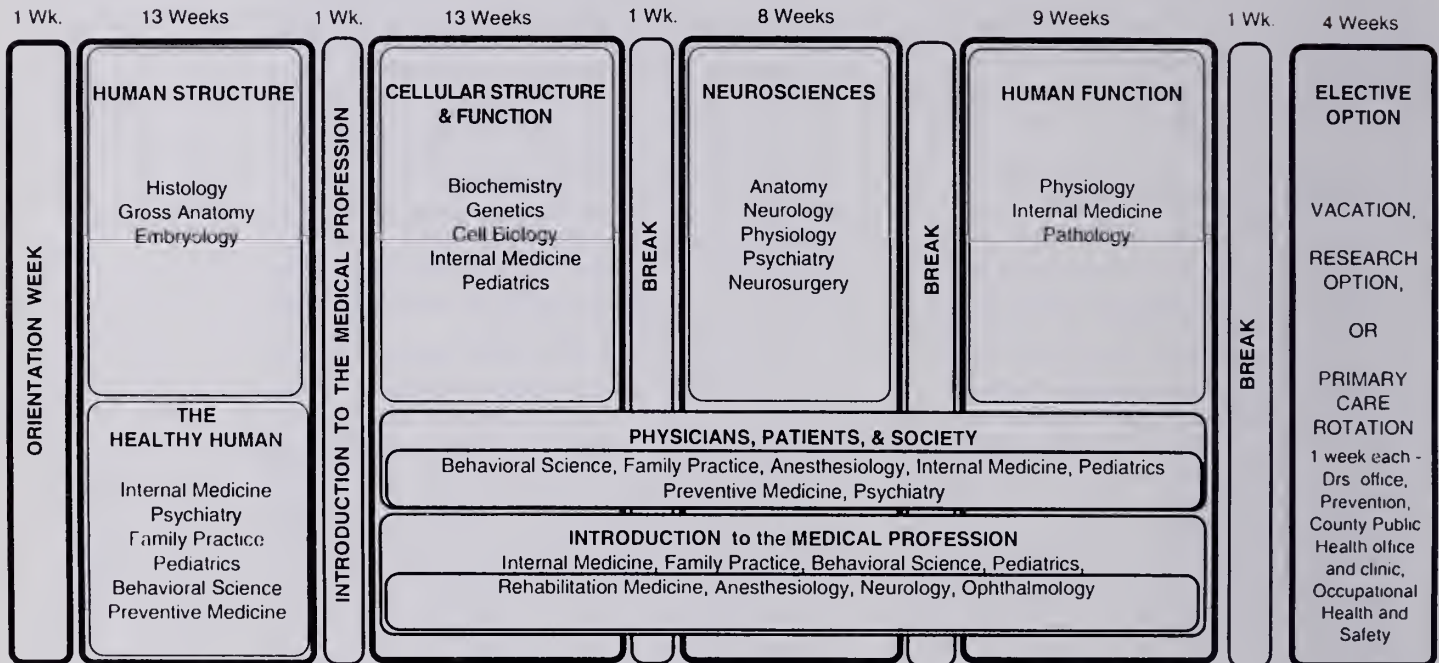
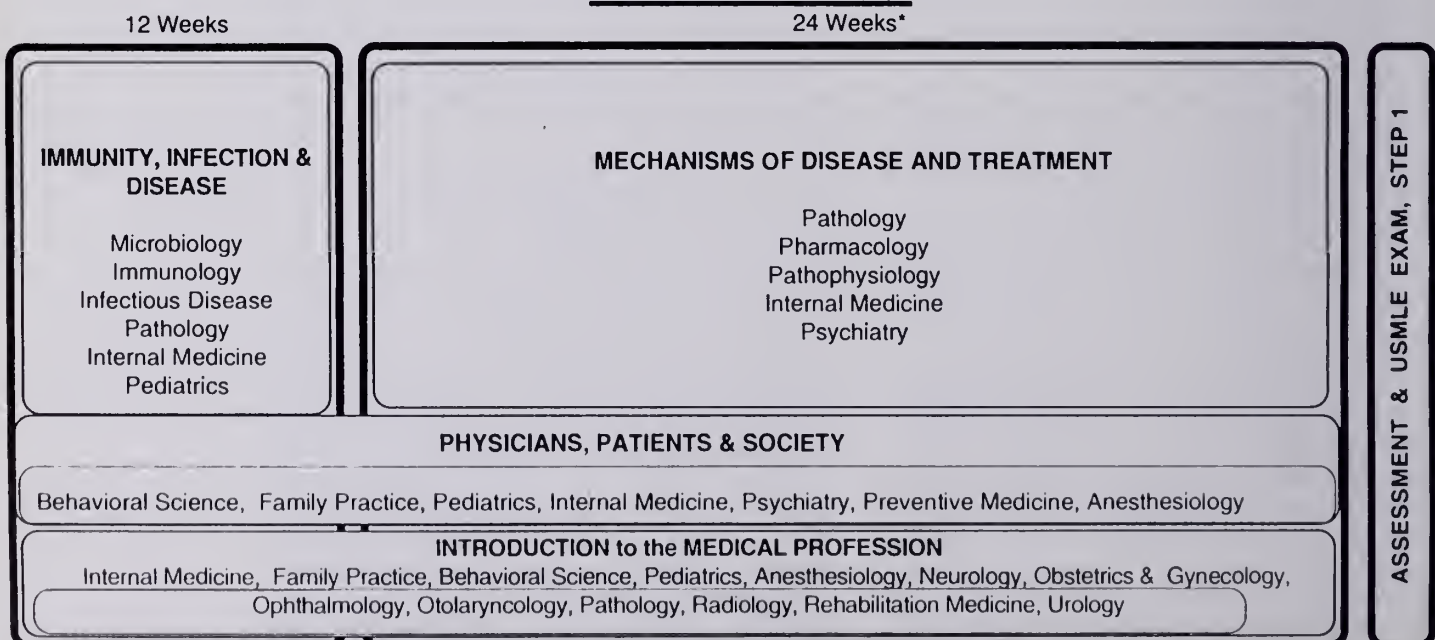
The key question for both premedical and medical educators concerning student preparation for medical school is actually very simple: What do students need to be able to do effectively in order to succeed, first in medical school, and subsequently (and more importantly), in the practice of medicine? Arguably, the two most important skills for physicians-in-training are communication and knowledge application (the wise use of knowledge in order that society may benefit). To begin to develop these skills, students applying to medical school should structure their undergraduate curriculum so that beyond the sciences it also includes: verbal and written communication; multi-cultural education so as to better understand and empathize with an increasingly diverse patient population; basic concepts of logic, statistics, ethics, and psychology; computer informatics; economics, small business practice, and quality management principles; and opportunities for the development of self-directed, lifelong learning skills.

### **Medical Education Reform at the University of Kentucky**

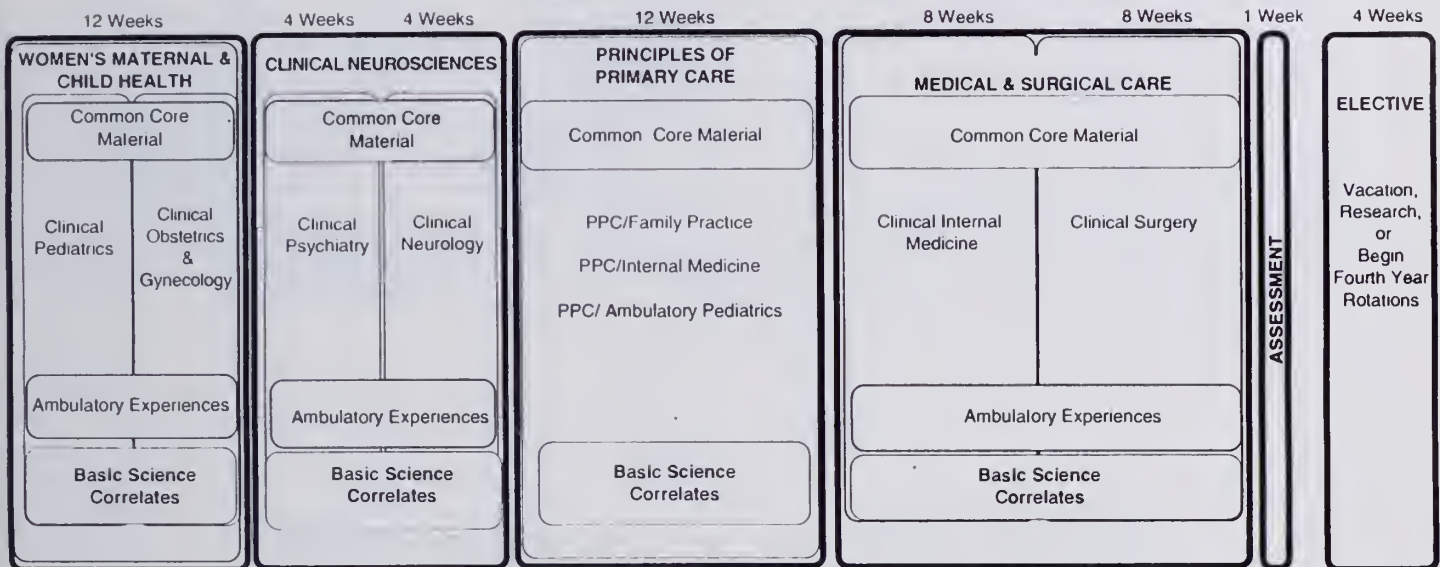
Medical education is in a state of change in the United States and the world. This has been prompted by many factors including recent national and international conferences and studies, pressures from the public for change, an explosion in biomedical information, and information regarding adult learning behavior and new methods for medical teaching. The University of Kentucky has recently implemented an entirely new curriculum which addresses these recommendations. While the College had begun to make major changes in the curriculum, it received added impetus from a major grant from the Robert Wood Johnson Foundation as one of only eight medical



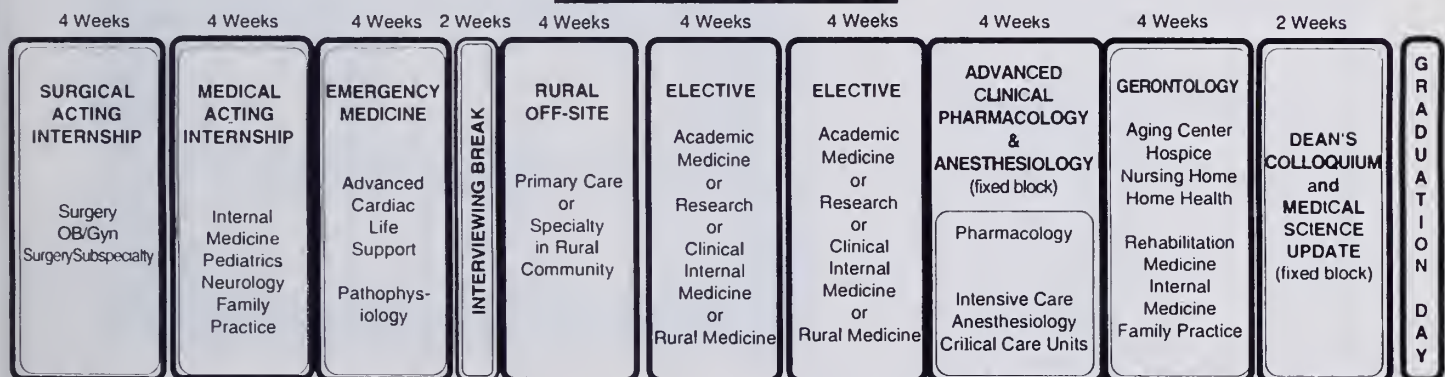
## Physicians for the 21st Century

**YEAR ONE****YEAR TWO**

## YEAR THREE



## YEAR FOUR



schools in the nation selected to develop new curricular models. The national recommendations and trends in medical education have been addressed in the new curriculum at the University of Kentucky. Specifically, the Kentucky Medical Curriculum focuses on these areas:

- Better integration of basic and clinical sciences
- Early exposure to clinical medicine in ambulatory care sites

- Health promotion and disease prevention
- Self-evaluation skills and lifelong learning abilities
- More ambulatory medicine and less hospital-based instruction
- Primary care
- Increased attention to communication skills, ethical, social, psychologic and financial impact of the disease upon the



## Physicians for the 21st Century

patient, family, and society.

In redesigning the study of the basic sciences, the Kentucky Medical Curriculum has shifted to a block system with intensive study of traditional courses over several weeks rather than several months. (See Curriculum Figs 1-2.) Blocks are designed to enhance the integration of the basic and clinical sciences to demonstrate the clinical usefulness and relevance of the sciences basic to medicine in practice situations. Through the Introduction to the Medical Profession course, students begin to learn the clinical skills of patient-history acquisition and physical examination techniques in the first year of medical school. In addition, during the first 2 years of the curriculum in the Physicians, Patients, and Society course, students study patient cases in small-group discussion settings to explore the psychological, cultural, ethical, and economic sides to the practice of medicine.

Throughout the curriculum, fundamentals of preventive medicine and the role of the physician in promoting good health are stressed. To promote active learning, the new curriculum is a mixture of traditional lectures, small-group discussions, problem-based learning sessions, demonstrations, tutorials, and laboratory studies. In addition, the new curriculum uses computer-assisted instruction to supplement learning, and in some cases, to replace traditional lectures with interactive learning sessions. Students are taught how to access information quickly from the National Library of Medicine and other sources.

Student progress is carefully monitored and evaluated. Before students move to their clinical clerkships, a full assessment of student clinical skills using standardized patients is conducted. Individuals trained to simulate real patients and assess how well the student performed an exam or procedure will assist students in areas needing improvement. Using this method, the students receive valuable feedback regarding history taking

and physical examination skills prior to confronting real patients.

The final 2 years of medical school provide more integration of disciplines (Obstetrics and Gynecology/Pediatrics, Neurology/Psychiatry, Medicine/Surgery, Primary Care), more continuity of care, and new emphasis on geriatrics, emergency medicine, and clinical pharmacology than ever before. (See Curriculum Figs 3-4.) Senior medical students are required to serve an "acting internship" in both a medical and surgical discipline to help build their confidence and technical proficiency prior to beginning their internship year.

Much of the learning required in medical school is, of necessity, the same as it has been in the past. Faculty at the College of Medicine have, however, looked carefully at the need for new approaches, new opportunities for integration, and new skills that are needed by graduates in an attempt to better prepare them for medical practice.

The 21st century is rapidly upon us. Fundamental changes in society are bringing about major reforms in health care delivery and subsequent changes in medical education. We must better advise our future physicians of the impact of these changes on their practices and help them to be well prepared for the myriad challenges of 21st century medicine.

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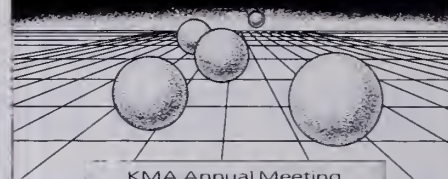
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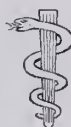
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# The Lesson of Humility

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*"We in medicine have long understood that, despite our magnificent advances against the diseases and ills of humankind, there is no place for arrogance in our endeavor to understand the nature of disease and to modify its outcomes."*

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**A**s the people of Oklahoma City and the nation at large both literally and figuratively sift through the rubble of the recent bombing, we have witnessed and participated in a myriad of emotions. In addition to the grief and pain, anger and outrage, hopelessness and loss, this tragedy has provoked the traditional rush to assign blame and seek redress that seems to have become an integral component of any American tragedy. While the perpetrators of the crime are still sought and their motives still speculative, the national conversation has quickly turned to the shared responsibility of radio talk shows, gun rights activists, foreign national and immigrants, and domestic and international law enforcement and intelligence agencies. The cries for enhanced police powers to combat terrorism grow louder each day, and with them grows the political will to realize such powers. Yet, as we wander through the aftermath of this event, we might perhaps take time to consider another lesson: the lesson of humility.

We in medicine have long understood that, despite our magnificent advances against the diseases and ills of humankind, there is no place for arrogance in our

endeavor to understand the nature of disease and to modify its outcomes. Our humility is rooted in the countless observations of patients recovering from illness after having been deemed lost, of patients succumbing despite our most strident efforts. It is reinforced when, just as smallpox is eradicated, AIDS emerges and tuberculosis rejuvenates itself. It sobers us as we begin to control communicable diseases only to be confronted with chronic illness and the dilemmas of an aging population.

We have learned that, in the face of tragedy, we must be caring and still maintain the perspective required to discern the natural history of the disease we are addressing, to understand its intricate mechanisms of action, and to discover its remedies. Whether it be bombings, earthquakes, airplane crashes, or any other seemingly indiscriminate disaster, all these events in the end remind us that whatever our powers, we cannot control everything in our lives. Perhaps the humble example that our medical profession has set in the face of such seeming futility might well serve our nation as a whole as it seeks to understand and cope with this tragedy.

**Daniel W. Varga, MD**



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- **COMMERCIALISM**, such as utilizing the name of sponsoring organization or facility, either on the exhibit or in printed materials, is **PROHIBITED**.
- KMA provides, without cost to the exhibitor, one 2 ft. table, bracket lights and a title sign.
- Spotlights, view boxes, furniture, decorations, etc, may be furnished by the exhibitor or may be rented, if desired, by applying directly to the George E. Fern Company, 3752 Crittenden Dr, Louisville, Kentucky 40209.
- Transportation and erection costs are the responsibility of the exhibitor.
- Exhibit must be attended during intermissions to answer physicians' questions. It is also desirable to have someone in attendance throughout the program.
- Equipment which will create noise must not be used during the general sessions and, at other times, must be controlled by head or earphones or a muffling device.
- Exhibit must be dismantled and removed by 4:00 PM, Thursday, September 22, 1994.
- Exhibit space is strictly limited to footage and space allotted. No exhibit may extend into the aisle.

Commonwealth Convention Center and the Kentucky Medical Association or its agents cannot guarantee against loss or damage and will assume no liability for damages nor guarantee the exhibitor against loss of any kind. The exhibitor agrees, with the Association, to be responsible to the Commonwealth Convention Center for damages that may occur as a result of the exhibitor's use of the facility.

# Annual Convention

## June 18-21, 1995

### The Drake, Chicago

The Alliance's Annual Convention meets at the same time as the American Medical Association. At a county or state meeting you may hear someone say, when will you get to the Drake? Are you coming into Midway or O'Hare? Do you ever drive? All these questions revolve around AMAA meetings that are in Chicago. As the State President and President-Elect we travel to Chicago three times a year. Other members are chosen to be part of the State Delegation for the Annual Convention. The Fall and Winter Confluences are for the State President, President-Elect, and four County Presidents-Elect per Confluence. The Annual Convention is similar to our State Conventions, but with more meetings and events to attend. The days are very full from early AM to sometime in the evening. First time attendees may feel like they are on a merry-go-round and when does it stop. There are many new faces for the first-time delegates and for some a large group of old friends who have been coming for many years.

Sunday will start with the AMA House of Delegates opening and Barbara Tippins, President, will present the AMAA contributions to AMA-ERF at the Chicago Hilton. We hurry back to the Drake to start the plenary session, hear committee plans, and for the presentation of the HAP Awards. The afternoon will continue with our Focus for '95-'96, a session for State Presidents and

Presidents-Elect. The official opening of the 72nd Annual Session will begin at 4:30 PM. Dr Robert McAfee will speak on "The AMA." Following Dr McAfee's speech the reception honoring Barbara Tippins and Sharon Scott will be held. So we have finished Day 1 at 7:30 PM, and its off to another state reception for some, a political reception for some others, and the rest of the group is ready for some good Chicago food and to return and put our feet up and unwind.

Monday will start with a 7 PM AMPAC breakfast and the presentation of the Belle Chenault award. Belle Chenault is an Alliance member who has been very active in campaigns for political and other arenas for many years. Her activities and goals have helped candidates get elected. The morning will round out with strategic plan, bylaws, health issues, organizational affairs, and voting for 1996 Nominating Committee. At 11 AM we eat again, and we usually are ready, too! Concentration and steady sessions burn up one's breakfast sooner than you'd think. Mary Matalin will be the luncheon speaker.

Monday's afternoon session starts at 1 PM and we go into the general meeting and finish with remarks by Percy Wooton, MD, President of the American Medical Association Education and Research Foundation and the presentation of some state AMA-ERF and Membership Awards. This usually ends after 5:30 PM, so



*Marla Vieillard*

everyone is ready for some free time to shop, sleep, meet relatives, or join the Kentucky group for dinner at a different Chicago restaurant. We try to choose a different style restaurant each evening so delegates get a chance to see what's available. Most of the restaurants we choose are within walking distance, but once in a while we opt for a couple of cabs and a new adventure.

Tuesday starts at 7 AM with State Caucuses. Kentucky will meet in the largest delegate room and while enjoying a room service breakfast, we will review resolutions, bylaws changes, or other issues to be voted on that day. We state our views and opinions so each delegate is well informed before they vote. We vote individually, not as a State. The general meeting will convene at 8 AM sharp and continue to 11:30 AM. We move to the Gold Coast room for lunch and a program by Capital Steps on political humor.

The general meeting will reconvene at 1:15 PM. We will



continue with state reports and the AMA-ERF and Membership Awards that weren't done previously. The Nominating committee will report followed by the election of officers. Priscilla Gerber, a national Past President, will do the installation. Sharon Scott will give her inaugural address and Mary Hanson, immediate Past President, will do presentations to the 1994-1995 President. We finish at 4 PM which is an agenda change, so members who wish may get home one day earlier. They may find that the tempo and pace is very tiring, and they will be glad to return to the format where the session ends on Wednesday about noon.

The Kentucky delegation will be staying until Wednesday to help and to be present for Dr Robert Goodin's reception on Tuesday eve. Gloria Griffin, Jo-Ann Daus, and Carol Goodin are the designated planners for Dr Goodin's reception. Dr Goodin

is running for an AMA office. The Kentucky Alliance officers and delegates will be putting out the word to support and vote for Dr Goodin. A few members may stay for the architectural tour of Chicago, as a post highlight, and attend the Inauguration Ceremony of Lonnie Bristow, MD, and the reception that will follow for he and Sharon Scott.

On arriving back to Kentucky most of us are ready for a few days of leisure and no hassle, but that won't be the case. The physicians will return to their practices and make up the days their partner or friend covered for them. The Alliance members will play catch up with family responsibilities and all the volunteer activities, a job, and projects they are committed to. We all are committed to supporting the AMA and AMAA, and even though these meetings are long and fast paced the Alliance and AMA are making

decisions to benefit all members and striving to do the best they can to improve the image of medicine and educate physicians and their spouses on the need to be politically active and aware of decisions that are being legislated that may affect their practices and lives. Support the Alliance and KMA; be active with us to protect patients' rights and the physicians who treat them. We can do so much more with everyone's support. The goal of the Annual Meeting is to form plans to benefit our members and to educate them on what is coming in the future and how to respond to it. This is not a time for apathy. A positive attitude and goals will unite us against those who don't understand the complexities of medicine and patient care. Make our voice heard. Share our Vision.

**Marla Vieillard**  
KMA Alliance President

## Avoiding A Two-Tiered Medical System

**T**O THE EDITOR: As it turns out this weekend was the first sunny weekend this year where it was really warm enough to sit out. I took my kids to the McDonald's to play and reexperienced first hand the achievements and limitations of American capitalism. I was able to get a cinnamon bun and a good cup of coffee for 99 cents and my children were able to play on a beautiful playground facility essentially for free.

On the other hand, as a physician I had the chance to observe the workers working very hard, diligently and carefully, and wondered how I was going to fulfill my responsibility to provide medical care to these workers. I am well aware that many of them are only given 35 hours of work a week so they are not considered full-time and do not receive any benefits. They are paid at or slightly above the minimum wage.

If we accept as a problem, then, to provide medical services for these workers and look at it from strictly an economic standpoint, we can formulate a problem which will lead to interesting speculation. The first principle is that medical services should not cost more than about an hour and a half to two hours of wages for the average worker. As such we would have to create a system where the cost of a basic medical evaluation including some limited evaluation and treatment, would have to be in the \$6 to \$8 range for a simple problem. An intermediate problem would have to be somewhere in the \$10 to \$12 range, and a complex problem in the \$15 to \$20 range.

While many readers will dismiss the following discussion simply as foolhardy, I would ask those with the courage to continue to bear with me.

How then can we technically and

legally create such a system?

Frankly, I don't think the main problem is technical; I think the main problem is legal. We have many techniques and methods which can create a more efficient medical system, but legally we cannot utilize them.

First of all, we do not make efficient use of physician extenders. In a system where a patient can be treated for \$6 it is unlikely that this patient would or needs to encounter a physician unless their problem proves recalcitrant to treatment. As such, a registered nurse should be able to see a patient, evaluate a simple problem after a patient history has been processed by a computer and a differential diagnosis printed, and provide a simple prescription for a patient. This prescription should consist of basic medications which are purchased in bulk, all of which could cost in the region of about \$6 for 5-10 minutes time. The role of the physician in this kind of setup is solely to monitor the nurse and to provide computerized support and quality control. For an intermediate problem the patient might be seen by a nurse practitioner or a physician assistant who would be under more intensive supervision by the physician. The physician may be in video contact as the practitioner examines the patient and be monitoring a number of technicians simultaneously at one time. The physician might only actually interact with the more complicated patient or patients who fail to respond to simpler measures. All of these practitioners would be linked by video and computer, not to each other but to specialists who would be on-line available to consult on more complicated problems. If a patient wishes to have a consultation with a specialist they could choose from a computerized list and the specialist would be in touch by video instantaneously in the physician's office for a certain predetermined price per minute, say \$2 to \$3 per

minute for a specialist of a certain type.

One of the important factors in this system is that there will be fewer physicians treating larger numbers of patients and using physician extenders and machines to accomplish almost all of the routine work. Technology such as the computerized x-ray equipment which does not require technicians and computerized laboratory equipment will provide rapid and noninvasive evaluations of patients. The physician may choose to have ultrasound and x-ray technology available at the bedside to immediately evaluate the patient's problem.

Such a system presupposes a great deal of self-help on the patient's part. Patients will not be encouraged to take expensive nonsteroidal anti-inflammatory agents, rather they will take Tylenol and generic Motrin and aspirin as needed and simple infections can be treated with generic antibiotics as needed.

Even to speculate about such a system of care brings us to the main obstacle to this care, our legal and regulatory systems, and this brings us to the heart of a crisis of American medicine. There can be no meaningful change in medical care in this country without a complete restructuring of our tort law systems and systems of regulation. This is currently the greatest barrier to improvement in medical care and to the creation of truly local and efficient medical care services in this country. HMOs are not going to accomplish this job. All HMOs can do is save 5, 10, or 15% at best. HMOs cannot take care of the very sickest patients, nor can they create a system that will truly operate more efficiently.

The only way that I can see that such a system can be set up and working is to create by law an exemption to our usual tort and regulatory systems for some small part of this country. In this part a group of scientists, technicians, physicians, and



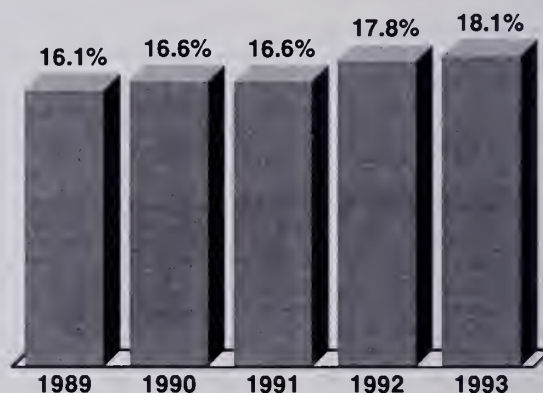
economists will create a new model of healthcare delivery and will have a patient population perhaps on the order of 500,000 people to serve with this new system. We have to be very clear that they will operate outside of all the normal boundaries of torts and legal regulations and their job will be literally to create a new kind of system from the ground up.

As extraordinary as all of this sounds, I don't believe that we can cure our problems with Medicare or Medicaid with any lesser solution. The alternative is literally the bankruptcy of the entire economy and/or the creation of a two-tiered medical system with a substantially inferior component as the lower tier.

F. Andrew Morfesis, MD  
cc: Newt Gingrich  
Jane Orient  
*Journal of the Medical  
Association of Georgia*

american society of internal medicine

### Non-elderly population without health insurance, 1989-1993



Source: Employee Benefit Research Institute, 1995  
Physician Payment Review Commission Annual Report to Congress, 1995

In spite of the attention focused on the issue during the health system reform debate over the last two years, the numbers of uninsured Americans continue to grow. In 1993, that number rose to 40.9 million—or 18.1 percent of the non-elderly population.

The American Society of Internal Medicine supports insurance market reforms that expand access to care by making health insurance more available, affordable and portable, with the goal of eventually attaining universal coverage for all Americans.

**SUPPORT  
RESEARCH.**

It Works Wonders.



# AMA's Physicians Capital Source Program Brings Physicians, Know-How, and Capital Together for Quality-First Health Care Delivery Networks

The AMA has created Physicians Capital Source, a program designed to help physicians build and lead *quality-first* health care delivery networks.

PCS gives physicians access to managed care, business, financial and legal experts who can help develop business plans and links with potential capital sources.

"Forming networks gives physicians the legal and financial responsibility to manage patient care and ensure quality," said Thomas R. Reardon, MD, AMA secretary-treasurer.

Many physicians lack experience in forming their own health care organizations and networks. Those interested with sound business plans find it difficult to obtain financing. Beginning in 1990 banks, venture capitalists and other investors began to realize the financial viability of physician ventures. In 1993 venture capital firms invested an 80% increase in health care service companies, and many of those dollars went to medical groups.

The first step for physicians participating in the PCS program is completing a detailed Request For Information (RFI), a blueprint for developing a business plan. The RFI helps physicians put their ideas into perspective and analyze their potential viability. The AMA gives participants a booklet, *Developing a Business Plan: A Physician's Guide*, to help them complete the RFI and write their plans.

PSC seeks business plans focused

on physician direction in patient care, medical decision-making, allocating resources and policy making. Plans should stipulate that physicians invest in and share the venture's risk, as well as serve on the board of directors.

Business plans must also detail how the venture would compete in the marketplace and how proposed arrangements with employers or others would benefit patients.

Physicians whose plans are approved are linked to potential capital sources such as banks, investment banks and venture capital firms (the AMA expects some applicants may not be approved). The program matches applicants with capital sources that can meet their short- and long-term financing needs.

Physician practices tend not to build the large amounts of equity necessary to form ventures and so require external sources of capital. On the other hand, hospitals and insurance and managed care companies have more equity and greater access to capital.

"With increasing corporate ownership of health insurance and managed care companies, we're concerned that the focus of health care delivery is shifting from quality patient care to profit," Dr. Reardon said. "Physician ownership and involvement will assure that quality remains the goal."

The cost of starting a physician organization varies widely, depending on the type. For example, the cost of starting up a "group practice without

walls" ranges from \$100,000 to \$1 million, said a study by The Advisory Board, an independent, not-for-profit, health-care think tank. Costs to start up a staff-model HMO can be as high as \$15.8 million for information systems, office space, medical equipment, legal fees, personnel and the purchase and/or start-up of medical practices.

Members of the PCS Advisory Committee offer participants advice and counsel during the application process. Committee members include experts in banking/investment banking, venture capital, technical systems (management information and administrative systems), physician governance, law and accounting, and managed care strategy development. They also evaluate completed business plans to determine if they are viable.

Initial business plan reviews and consultations are provided to AMA members at no charge for professional time. Subsequent consultations, at participants' discretion, are billed at regular rates. The initial consultation costs nonmembers \$1,000.

For information call the AMA's Managed Care Helpline (1-800/AMA-1066).



## Board of Trustees Spring Board Meeting



**President Robert R. Goodin, MD, introduced Republican Gubernatorial candidate Larry Forgy, standing in background, as KMA Past President and current KMA Committee on State Legislative Activities Chair Wally O. Montgomery, MD, pondered his comments.**

**T**he KMA Board of Trustees met in regular session on April 12-13, 1995, at the Oxmoor Country Club in Louisville. The Board members heard reports from the President; Secretary-Treasurer; Alliance President; Dean, University of Louisville School of Medicine; President, Board of Medical Licensure; and the Vice Chair, KMIC Board of Directors. In addition, three of Kentucky's main Gubernatorial candidates made presentations to the Board and provided written responses to questions relating to health care that had been sent to them before the meeting.

The Board members provided direction to legal counsel regarding future steps in the Medicaid reimbursement lawsuit KMA had previously filed, and agreed with the Executive Committee that legal action regarding HB 250 was not warranted at this time.

Extensive reports were given on different aspects of the Kentucky Health Policy Board including updates on practice parameters, Certificate of Need, standard benefit plans, and fraud and abuse regulations.

The Board members congratulated Past President Ardis Hoven, MD, on her appointment to the HCFA Practicing Physicians Advisory Council; and approved an expenditure of up to \$5,000 for a "Litigation Center" the AMA is establishing for the benefit of contingent medical associations. In other action, the Board approved four KMA group health plans presented by the KMA Insurance Agency; authorized expenses from the public relations budget for prelegislative

conferences and cosponsorship of a seminar with the news media; and asked the Awards Committee to consider special recognition for physicians who participate in the Kentucky Physicians Care Program.

The Board also adopted a budget for the 1995-96 fiscal year; authorized reappointment of three Class B Directors on the KMIC Board of Directors; approved wording changes to the KMIC Articles of Incorporation; and selected nominees for service on Governor-appointed councils and boards.

The KMA Board of Trustees will hold its next regular meeting on August 9-10, 1995, at the Oxmoor Country Club.

*KMA*



**Democratic Gubernatorial candidate and current President of the Kentucky Senate John "Eck" Rose.**



*L to R, Republican Gubernatorial candidate Bob Gable elicited smiles from President Robert R. Goodin, MD, and KMA Past President and current State Representative Bob M. DeWeese, MD.*

Gubernatorial candidates made presentations to the Board and provided written responses to questions relating to health care.



*During a break in the meeting, KMA 12th District Trustee, Scott B. Scutchfield, MD, left, and KMA President Robert R. Goodin, MD, right, were pictured with fellow KMA member and Democratic Lieutenant Governor candidate, Stephen L. Henry, MD.*



*L to R, KMA Executive VP Robert G. Cox, Board Chair Donald R. Stephens, MD, and President Robert R. Goodin, MD.*



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**PEOPLE**

Earlier this year, the *Congressional Record* included a tribute by Senator Wendell Ford to KMA 2nd District Trustee **Donald R. Neel, MD**, Owensboro. Senator Ford recognized Dr Neel for being named recipient of the 1994 Physician's Award for Best Notifiable Disease Reporter by the Kentucky Department of Health Services.

The Department recognized Dr Neel for his longstanding support of community health, particularly his efforts to contain the outbreak of an acute infectious disease last fall.

**Reginald Finger, MD**, chief epidemiologist for the Department of Health Services, presented the award at Dr Neel's Owensboro office.

"Dr Neel represents the very essence of public health in his efforts to detect potential health hazards and then prevent the spread of these diseases to others," Dr Finger said in his presentation. He noted that without Dr Neel's early actions last fall, many more children would have come down with shigellosis. "Dr Neel is being honored for that and more — throughout his career, he has been a strong supporter and partner of the local health department in Owensboro. Dr Neel's career has been characterized by an unending zeal to improve the health and wellbeing of children — all children, added Dr Finger.

**J. David Richardson, MD**, a Louisville general surgeon, was recently inducted into the Murray State University Hall of Fame. Dr Richardson, a Morehead native and 1966 graduate of Murray State, is professor/vice chair of the Department of Surgery and chief of the Division of Surgery at the University of Louisville School of Medicine.

**David H. Adamkin, MD**, a Louisville pediatrician, has been elected to membership in The American Pediatrics Society.

**Nemr Salem Eid, MD**, U of L Department of Pediatrics, attended last June the International Congress on Pediatric Pulmonology in Nice, France, where he was appointed to serve on the Consultative Board of the second Congres International de Pneumologie Pediatrique International (CIPPIL).

**Joseph S. Sanfilippo, MD**, a reproductive endocrinologist in the U of L Department of Obstetrics and Gynecology, has been elected to the board of directors of The American Fertility Society. He also recently returned from the Philippines and Thailand, where he helped establish endoscopic surgical units at the Chulalongkorn University Hospital in Bangkok and the University of Santo Tomas in Manila.

**Richard S. Wolf, MD**, a Louisville pediatrician, received the Roger Fox Award from Kosair Charities in honor of his efforts in children's health care.

**Jeffrey P. Callen, MD**, a Louisville dermatologist, recently was elected to the board of directors of the American Academy of Dermatology, to begin serving in February 1996.

**Kiser, MD**, Trover Clinic, Chairperson; **Donna Skinker, MD**, UK, Delegate to the AMA-RPS; **LeRoy Gallenstein, MD**, St. Elizabeth's, Alternate AMA Delegate; **Judy Linger, MD**, UK, AMA Delegate; and **Mehmet Akaydin, Jr, MD**, U of L, Alternate KMA Delegate.

The Section plans to introduce a resolution to the AMA-RPS in June on ensuring opportunities for medical students and residents to vote in local and national elections and discussed ways for residents to be more involved in legislative activities at the state level.

### **Mission to the Golden Triangle, Thailand, and Iran Java**

The Christian Medical Association (CMA) is recruiting general practitioners, internists, surgeons, ophthalmologists, obstetricians, gynecologists, cardiologists, dentists, and general nurses to provide free medical, dental, and surgery services for the very poor of the hill tribes in North Thailand and/or the Balim Valley of Iran Java.

The volunteer medical teams will help 10 village clinics per day and refer people for surgery and follow-up to local hospitals.

The CMA, a 25,000 member physician and dentist association with 30 years' experience in providing short-term medical missions, will cosponsor this program with the Indonesian government Health Department. CMA will provide all training and administration.

The Golden Triangle will include trips to Burma and Laos, visits to the local sites and the Burma Road area. Dates are November 10-25, 1995. The Balim Valley of Iran Java and mountain villages will be February 10-25, 1996.

For more information or to donate funds for medicine, contact CMA, PO Box 3501, Seal Beach, CA 90740 or call 310/592-3791.

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**UPDATES**

### **Resident Physicians Section Elects 1995 Officers**

**Robin Floyd, MD**, a U of L diagnostic radiology resident, has assumed the office of President of the KMA Resident Physicians Section. Other 1995 officers elected were **Kyle**

### Humana Hospital-Lexington Made Contribution to Local Charity for Doctors' Day

The medical staff of Humana Hospital-Lexington is putting their financial focus on the medical needs of the community.

In observance of Doctors' Day, a day during which physicians traditionally are honored with special meals, gifts, and other forms of appreciation, the medical staff of Humana Hospital-Lexington requested that the funds be contributed instead to Lexington's Nathaniel Mission. The Mission supports the city's culturally and racially diverse population by providing health clinics, spiritual aid, and emergency relief programs. The organization was selected by the medical staff and its president, **David A. Gammon, MD**, because it offers assistance to as many as 5,000 underprivileged, inner-city citizens each year.

### "Harvesting" Allows Paraplegics to Father Children

The University of Louisville reports that urologist **Arnold M. Belker, MD**, is 4-for-4 in "harvesting" healthy sperm from his paraplegic male patients that resulted in pregnancies for their mates.

Using a microsurgical procedure known as vas aspiration, Dr Belker removes more numerous, more motile sperm from the vas deferens than those acquired by more traditional means. The technique seems to be equally successful whether the mate's egg is fertilized in test tube or in the womb.

### Early Detection of Glaucoma

University of Louisville ophthalmologist **Robert D. Fechtner, MD**, is using new screening methods for glaucoma that may help catch the

disease before the damage is too great.

Dr Fechtner uses computer imaging to measure tiny nerves inside the eye. At the first sign of deterioration, doctors can intervene. According to the University report, that early treatment often can help stop glaucoma in its tracks.

### Vital Statistics

The Vital Statistics Branch of the Department for Health Services would like to encourage physicians to be more aware of filing and reporting vital records.

For vital records to be used effectively for public health purposes, it is essential that all events be properly recorded and filed on time. The exclusion of a significant number of records, particularly for events of low frequency or from rural areas, may seriously affect the value of data for public health uses. Furthermore, individuals may be seriously inconvenienced or denied benefits to which they are entitled if information is not accurate, or the certificate is not filed in a timely manner.

Kentucky statutes require that the attending physician complete and return the certificate of death within **five working days** after its receipt from the funeral director or person acting as such. Some physicians believe that the pronouncing physician is responsible for signing the certificate of death. However, physicians should be aware that the pronouncing physician is rarely familiar with the medical history and cannot list an accurate or complete cause of death.

Information regarding death certificates may be referred to Vital Statistics at 502/564-4212 extension 220, Monday through Friday.

### KMA Fax Line

The KMA is implementing a fax broadcast service. With this additional communication outlet we will contact you immediately with late breaking important news and events. We are particularly interested in enrolling as many physicians as possible on the KMA fax line prior to the 1996 Kentucky General Assembly.

During the Session, the KMA legislative newsletter will be faxed on Thursday evening and on your desk when you arrive Friday morning. Contact can be made with legislators over the weekend on important legislative events. There is no charge to your office for the transmission.

### Join the KMA Fax Line

Please complete this form and mail to KMA at 301 N Hurstbourne Pkwy, Louisville, KY 40222; phone with details 502/426-6200; or fax to KMA at 502/426-6877.

\_\_\_\_\_  
Physician's Name (type or print)

\_\_\_\_\_  
Group Name if Applicable

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Fax Number



# NEW MEMBERS

*Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.*

## Boyd

**Jack L. Armstrong, MD** — IM  
RR 1, Box 2153, Greenup 41144  
1990, Pennsylvania State

## Boyle

**Jeffrey T. Hinton, MD** — OBG  
224 W Lexington Ave, Danville 40422  
1984, U of Kentucky

## Calloway

**William A. Holman, MD** — C  
300 S 8th #282W, Murray 42071  
1967, U of Louisville

## Daviess

**William H. Milnor, Jr, MD** — ORS  
2211 Mayfair Ave #305,  
Owensboro 42301  
1971, Baylor College  
**Olwale O. Olusola, MD** — P  
2030 E 22nd St, Owensboro 42301  
1985, U of Lagos, Nigeria

## Fayette

**Ronald G. Fearnow, MD** — PD  
3650 Boston Rd #1, Lexington 40514  
1959, Commonwealth Univ  
**Craig Nachbauer, MD** — TS  
168 Burt Rd, Lexington 40503  
1976, Ohio State Univ  
**Elizabeth A. Piercy, MD** — ID  
1760 Nicholasville Rd #502,  
Lexington 40503  
1983, Jefferson Medical Coll of  
Thomas Jefferson

## Harrison

**Gerald R. Harpel, MD** — OBG  
PO Box 68, Cynthiana 41031  
1973, Boston Univ

## Jefferson

**Allen G. Deam, MD** — C  
225 Abraham Flexner Way #305,  
Louisville 40202  
1987, Ohio State Univ  
**George A. Kargas, MD** — AN  
2400 Mellwood Ave #1116,  
Louisville 40206  
1990, Univ of Wisconsin  
**Robert J. Middleton, MD** — IM  
407 Lyndonwoods Cir,  
Louisville 40222  
1982, St George's Univ  
**Michael W. Sutkamp, MD** — IM  
1133 Blackthorn Rd, Louisville 40299  
1990, U of Louisville

## McCracken

**Paul J. Johnson, MD** — R  
135 Mimosa Ln, Paducah 42001  
1990, U of Kentucky  
**David L. Wadley, MD** — R  
PO Box 8329, Paducah 42002  
1984, U of Arkansas

## Northern Kentucky

**Creighton B. Wright, MD** — TS  
2123 Auburn Ave #401,  
Cincinnati OH 45219  
1965, Duke Univ

## In-Training

## Fayette

**Bruce G. Kinzy, MD** — PMR  
**John W. Marshall, MD** — FP  
**Laura A. Wright, MD** — P

## Jefferson

**Mark S. Cornett, MD** — R  
**Robert H. Lewe, MD** — S  
**Julia A. McDonald, MD** — PD  
**Sharon M. Merker, MD** — IM  
**William J. Welch, MD** — IM  
**Andrea R. Woolfolk, MD** — PD  
**Gregory M. Woolfolk, MD** — IM

## IMPORTANT NOTICE

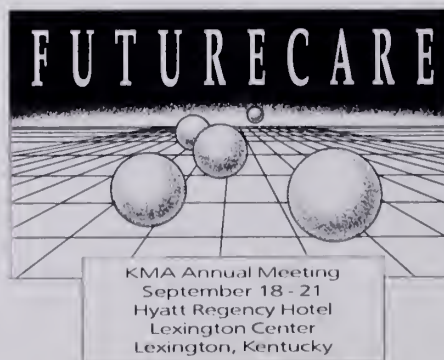
### RELOCATION OF IMPAIRED PHYSICIANS PROGRAM

The  
Impaired Physicians Program  
has moved  
its headquarters from the  
Kentucky Medical Association  
301 N Hurstbourne Pkwy  
to the following address:

**Impaired Physicians Program**  
**9000 Wessex Place, Suite 305**  
**Louisville, KY 40222**

New Phone Number  
**502/425-7761**

New Fax Number  
**502/425-6871**



## Liability Reform:

# AMA Scores BIG Legislative Victory

By Robert E. McAfee, MD  
President, American Medical Association

On March 9, medicine scored one of its biggest legislative victories ever when the House of Representatives, in a bipartisan vote, approved an AMA-backed amendment that would place a \$250,000 cap on pain-and-suffering awards in medical malpractice cases.

This historic vote came as a result of an all-out lobbying effort by your American Medical Association and many other medical organizations. It was a blockbuster victory for the AMA, the medical profession, and every practicing physician.

Liability reform has been at the top of medicine's legislative agenda for as long as most of us can remember. Now, after 20 years of tirelessly campaigning, we can claim a major win in Washington.

That's the good news. The not-quite-so-good news is that the legislation still has to go before the Senate, where the proposal is certain to be a prime target of the trial lawyers' lobby. So our task is only half complete. The vote there is likely to take place in the next few weeks, and before then we'll probably be calling on all of you to contact your senators and let them know where you stand.

Meanwhile, here are some of the things we've done, and are continuing to do.

1. We've mobilized the efforts of state and county medical societies and national specialty organizations to join us in this effort. In late March we sent a letter to every Senator that was signed by the medical societies of all 50 states and the District of Columbia and by 81 specialty societies, demonstrating their unity in calling for tort reform. In addition to limits on damage awards, we are seeking an expansion of the joint-and-several liability reforms to all defendants, not just those who sell products. The AMA Alliance also sent letters to every county legislative chair in the home districts of members of the Senate Judiciary Committee, urging them to call and fax their support for liability reforms.

2. We've gone directly to Capitol Hill. We urged state societies to contact their representatives one-on-one in their districts during the President's Day recess, and many did so. During our recent National Leadership Conference in Washington, we held a reception for members of Congress and followed that up with one-on-one visits with members of Congress by physicians and delegations of physicians.

3. We've also gone public with our message. We've sponsored drive-time ads on Washington's top radio stations, rebutting some scare tactics used by the trial lawyers. We've

placed print ads in the Wall Street Journal and in Capitol Hill publications. And we've sent our message to the editorial writers at all of the nation's top newspapers, with facts to back up our arguments.

The public is listening. A Gallup survey showed that more than 71% of Americans favor liability reforms, including caps on pain and suffering awards. Clearly, many of our patients are on our side. But we can take nothing for granted.

Tell your patients! Tell your colleagues! Tell your representatives in Congress! The AMA and organized medicine throughout the US are leading the more than 700,000 physicians of America in the battle for liability reform. Congress must know we will not stop until the job is done.

As this is being written, liability reform is at the top of our priorities. But Medicare reform and the AMA's 1995 Patient Protection Act also will receive our major attention in the coming days and months.

Together, organized medicine is fighting for legislation that will allow you to care for your patients to the best of your ability and conscience. I invite all of you to join us in that fight.

*(For additional information on the AMA's legislative programs or for materials suitable for sharing with your patients, contact the AMA Dept of News and Information, 312/464-4430.)*



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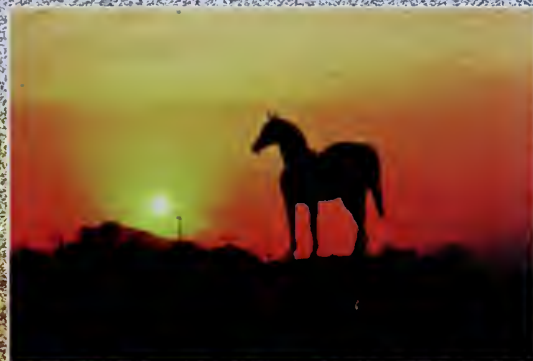
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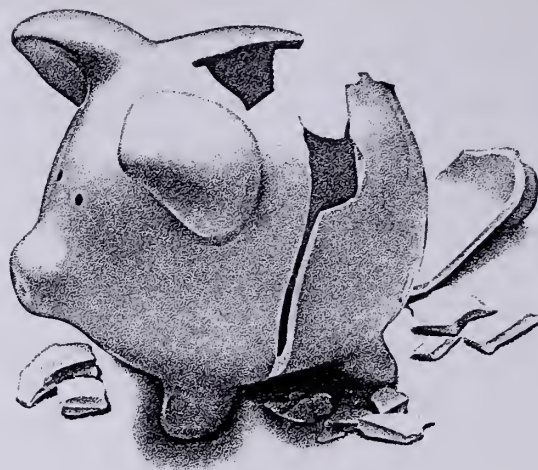
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JULY 1995

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**COVER:** Lexington, host to the KMA Annual Meeting, Sept 18-21, has captured a reputation not only as thoroughbred capital of the world, but also as one of America's thoroughbred cities and a first-class meeting and convention site. The area is replete with history, charm, upscale shops, and cultural enticements. See page 282 for a brief glimpse and mini-guide of the "Heart of the Bluegrass." Design by Lee Wade of Louisville. Photos courtesy of the Lexington Convention & Visitors Bureau.

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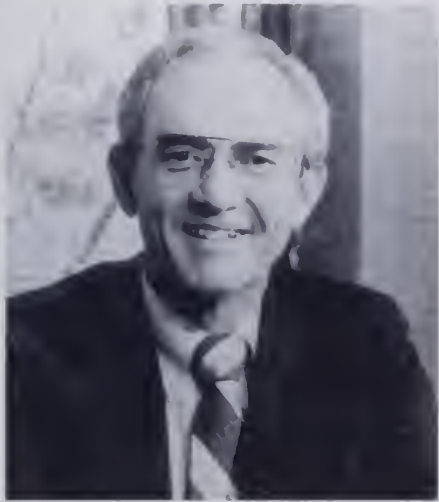
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## Medical Stewardship

---

**"As we struggle with the marked changes taking place in our profession and in health care delivery today, it seems to me an opportune time for us individually and collectively to ask ourselves the question "are we being good enough stewards of our profession?""**

---

I wonder what thought the word *stewardship* conjures up for you. When I hear that word, I immediately think of the Chairman of my church Stewardship Committee calling to convince me to give more money this year than I did last year, or even worse to ask me to serve on the Stewardship Committee and generate contributions from others.

Webster defines stewardship as: *manage for others*. This obviously can vary from management of food and table service in a restaurant to management of our profession, the key element being "to manage for others' use." One of the finest examples of stewardship in medicine that I have seen was the recent one million dollar donation by Drs Lita and Sam Weakley to the University of Louisville School of Medicine to endow a chair in surgical oncology. For the many of us who know and admire Lita and Sam, we are not at all surprised. This is more than gratitude folks, *this is stewardship at its finest*. There are many more excellent examples in our profession such as the recent generous donation of Dr Tom and Sylvia Watson of 1.2 million dollars to the University of Louisville English Department.

I have recently become a fan of Stephen Covey's books focusing on leadership. His institute consults for a

variety of businesses and professions to help them deal with everything from declining sales to internal strife. The recurring theme of his teachings is leadership based on principles, and many times solutions are dependent primarily on improved stewardship toward one's own profession or business. As we struggle with the marked changes taking place in our profession and in health care delivery today, it seems to me an opportune time for us individually and collectively to ask ourselves the question "are we being good enough stewards of our profession?" Can we in fact give more than we already do? How do we encourage our colleagues who freeload the profession to give back at least a little to help preserve our profession for future generations, as our predecessors have done for us?

This article does not for one second mean to suggest that most Kentucky physicians are not already excellent stewards. Most share the enormous pride that I have for our profession and give generously. Let's look at some of the areas for *giving* and hope we can stimulate more sharing by more doctors.

### Provision of Free Medical Care

The vast majority of physicians care for patients regardless of ability to



pay. This occurs even in the face of unrelenting assaults we have received from Frankfort in recent years. It is estimated that the average US physician provides 150 hours of free medical care per year. That is about 2 weeks of work for the average physician — 3 weeks for most workers. Let's continue to encourage even more free service to poor Kentuckians simply because it is the *right thing to do*.

### Organized Medicine

We all recognize that our medical societies could do a better job of representing us. Many Kentucky physicians recognize the importance of a team effort, and not only belong to their county, state, specialty, and American Medical Association, but also contribute countless hours of often thankless work in medical society activities. Until we can re-engineer a more effective federation of medicine, as is being attempted, I believe we all can agree that our medical societies remain essential to assure physician representation. It is time for *all physicians to participate*, not just by paying dues, but by *getting involved* and *sharing ideas*. Help us

get the uninvolved physicians to become active contributors of dues and ideas.

### Politics

To me the most difficult area for *stewardship in medicine* is the political arena. My basic dislike for politics, along with the political responsibilities that go with KMA leadership, has grown rapidly over the past couple of years. The political system seems to breed compromise of one's principles, a concept unthinkable to our profession. There can be *no compromise of quality in health care*. Thankfully we do have Kentucky physicians willing to do the required educating and lobbying of legislators that is required to assure availability of health care to Kentuckians. Four of our Kentucky physicians currently serve in the Kentucky General Assembly and are certainly to be applauded and supported. Kentucky physicians have done a better job in the past 2 years of communicating with legislators and supporting candidates who share our views. It is critical that stewardship in this area improve even further, starting now. Please join KEMPAC (only 18%

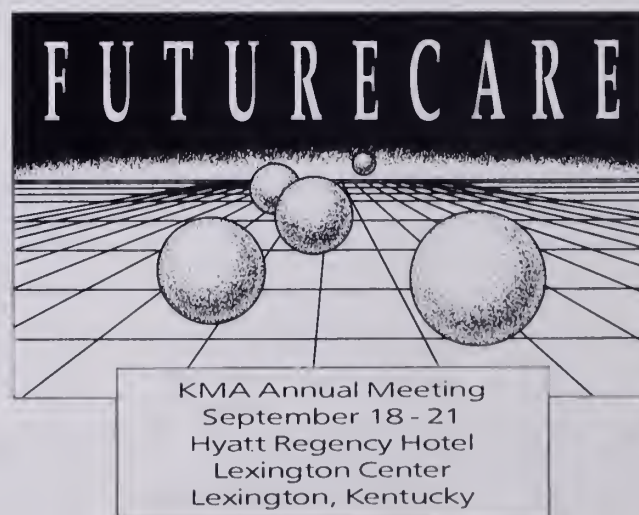
currently belong) and support directly with your money and time candidates who share your views.

### Patient Care

The *ultimate stewardship in medicine*, of course, is delivered at the bedside in that revered patient-physician relationship. Let's not get caught up in the production-line medical care being promoted by today's managed care systems and forget our patients' needs. Let's provide the right amount of care, neither too much nor too little. The practice of medicine requires an equal dose of **head, heart, and hand**. Lack of any one of these is simply not acceptable. We must always remember that our patients remain the most important reason for us to be generous with our stewardship for the medical profession.

As I write this article in a Chicago hotel room for a weekend committee meeting, with beautiful golf weather outside, I can't help but ask myself "is it worth it?" The answer is loud and clear, "Hell yes it is."

**Robert R. Goodin, MD**  
KMA President



# MONITORING MEDICINE

## NEWS FOR KENTUCKY PHYSICIANS

### KMA PATIENT EDUCATION COMMITTEE

A legislative handbook to assist physicians' communications with patients, legislators and the media will be mailed in July. The project is under the direction of the Patient Education Committee chaired by Preston P. Nunnelley, MD, of Lexington. The Handbook will include information on Medicaid, the provider tax, tort reform and other issues of importance to patients and physicians. The following are some examples utilized to present factual information to the public.

## Facts & Fables Kentucky Physicians and Medicaid

### 1994 Medicaid Payments To Physicians

Amount Paid	Physicians Receiving Amount	Percentage of Total
0 - \$ 4,999	3,594	59.9%
\$5,000 - \$ 9,999	526	8.8%
\$10,000 - \$ 19,999	571	9.5%
\$20,000 - \$ 29,999	259	4.3%
\$30,000 - \$ 39,999	320	5.3%
\$40,000 - \$ 49,999	52	0.9%
\$50,000 - \$ 99,999	389	6.5%
\$100,000 - \$ 200,000	208	3.5%
\$200,000+	82	1.4%

The table above shows the payments made to all 6,000 participating physicians.



The pie chart graphically shows the large percentage of physicians receiving less than \$5,000 annually.

Medicaid  
pays  
doctors  
less than  
\$5,000  
per year!

The 3,594 physicians who received less than \$5,000 represent nearly 60% of all physicians who treat Medicaid patients.



## Physicians services valued below taxi drivers!

A review of all Medicaid payments for Fiscal Year 1994 on a "per patient encounter" basis shows physicians are paid less per patient visit than Dentists, Family Planning Clinics, Ambulance services and Non-Emergency Transport companies.

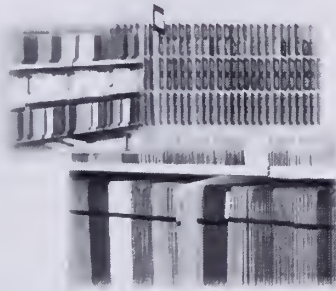
### Average Medicaid Payments Per Utilizing Recipient

Paid to:	Amount	Total Paid:
1. Residential Facility	\$8,601.99	3,096,716.00
2. Mental Hospital	6,705.49	27,484,863.00
3. Public ICF-MR	6,254.64	50,306,473.00
4. Private ICF-MR	4,057.25	20,545,931.00
5. AIS-MR (Alternative institutional services)	2,621.38	25,165,278.00
6. Inpatient Hospital	2,493.44	390,112,875.00
7. Hospice	2,409.48	8,558,480.00
8. Nursing Facilities	1,791.83	358,364,358.00
9. Ambulatory Surgical	934.75	6,281,520.00
10. Adult Day Care	715.39	706,845.00
11. Renal Dialysis	672.47	3,760,431.00
12. Basic Home Health	460.24	45,107,905.00
13. C.O.R.F. (Community occupational rehabilitation facility)	336.24	286,479.00
14. Emotionally Disturbed Children	317.39	3,184,030.00
15. HCBC (Home and community basic care)	299.74	13,735,609.00
16. Mentally Ill Adults	269.02	4,196,775.00
17. Mental Ill Health Clinic	256.62	49,149,375.00
18. Outpatient Hospital	226.80	167,580,958.00
19. DME Suppliers (Durable medical equipment)	195.81	19,404,264.00
20. Dental	141.45	37,800,476.00
21. Ambulance	127.64	12,567,513.00
22. Non-Emergency Transport	125.65	16,526,019.00
23. Family Planning Non-Clinic	123.13	10,954,670.00
24. Physician	123.04*	259,683,208.00
25. EPSDT (Early periodic screening diagnosis & Treatment)	116.07	6,128,279.00
26. Primary Care	116.02	28,493,480.00
27. Nurse Anesthetist	112.83	1,065,578.00
28. Preventive Services	99.86	16,851,541.00
29. Rural Health	96.55	2,409,357.00
30. Optician	91.22	387,511.00

\* A 20% reduction in Medicaid fees to physicians has been implemented. A 20% reduction in the average fee will reduce the physician figure to \$98.43.

SOURCE: Trends of Medicaid in Kentucky, Fiscal Year 1994, Cabinet For Human Resources

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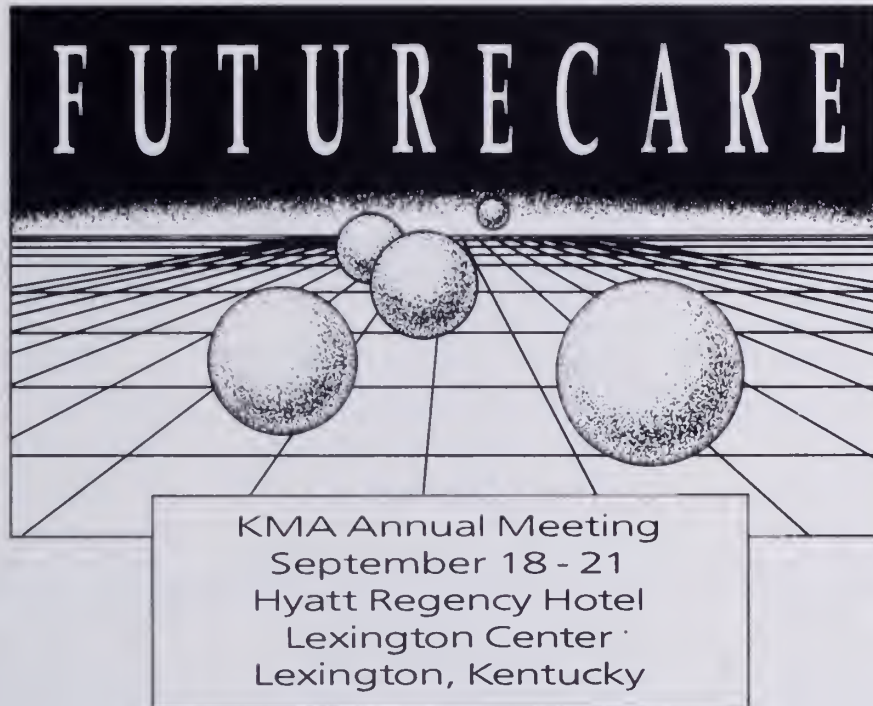
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## “Heart of the Bluegrass” Hosts 1995 KMA Annual Meeting

The futuristic 1995 KMA Annual Meeting logo, depicting the theme “FutureCare,” projects an imagery of the cutting edge, high-tech scientific programming and exhibits designed for your continued education and practice management to be featured at this year’s Annual Meeting. The site of the meeting, Lexington, Kentucky, is a highly progressive, innovative, thriving city adapting to the future with ease. However, the general location of the meeting in the multi-county region known as the “heart of the Bluegrass,” speaks more to a slower-paced, bygone era. Many of the historical landmarks, with names as diverse as the attractions found there, are legendary while some of the past is still being delightfully discovered.

A drive through Versailles, Georgetown, and Paris takes you past historic sites such as Georgetown’s Ward Hall, a covered bridge in Bourbon County, and the historic town of Midway.

Midway is a railroad town that looks much the way it did in the 1800s. Small shops filled with antiques and quaint tea rooms line both sides of Railroad Street. Entering the old buildings gives one a sense of discovery. The creak of floorboards and the heavy air that is always present in antique shops is a contrast to the light scent of fresh flowers on the table in the tea rooms.

Central Kentucky has another quaint village of a completely different flavor. Shakertown at Pleasant Hill is a restored community

of original Shaker buildings that now house a restaurant, exhibits and craftsmen demonstrating Shaker crafts. The sterile feeling of the white walls and uncluttered simple furnishings exemplify the Shaker philosophies as described by the costumed guides.

The drive from Lexington is a scenic road that winds along the palisades of the Kentucky River. A paddle-wheel riverboat is docked at the Village and offers daily excursions.

Shakertown is part of a historic triangle. Other sites include a reconstructed colonial fort at Harrodsburg, a park and museum where a Civil War battle was fought in Perryville, and Constitution Square in Danville.



## "Heart of the Bluegrass"

Driving out of Lexington to the southeast, you can visit the fort where Daniel Boone settled and the small college town of Berea. *Unusual* is the best way to describe Berea where students must work for the college to pay tuition. The jobs are not the expected work-study positions. Many are employed as weavers, potters and furniture-makers. The famous spoonbread of Boone Tavern Hotel is also served by students.

Government and politics has always been a focal point of Central Kentucky. Senator Henry Clay's home is in Lexington. The State Constitution was framed in Danville and the present State Capital is in Frankfort, just minutes from Lexington.

But the marble halls of state buildings are a sharp contrast to the rustic distilleries of Franklin County. The heavy aroma of fine Kentucky Bourbons fill the air both inside and out of the distilleries.

The area described above requires some driving but you will find that Lexington is a convenient hub city. Making short day-trips from Lexington hotels is a relaxing way to see and do a lot without wearing everyone out.

Located within the city of Lexington are many fine attractions including the following:

**AMERICAN SADDLE HORSE MUSEUM** — A museum located on the grounds of the Kentucky Horse Park, dedicated to the oldest registered American horse breed — the American Saddle Horse.

**ASHLAND, HOME OF HENRY CLAY** — The home of statesman Henry Clay, a United States Senator and Speaker of the House of Representatives. This 1811 historic house is filled with family papers, portraits and possessions.

**THE BODLEY-BULLOCK HOUSE** — Built in 1814, this house served as Union Headquarters under Generals Burbridge and Gilmore during the Civil War.

**DUDLEY SQUARE** — Historic

renovation of 19th century schoolhouse combines charm and elegance in a unique shopping atmosphere. Contains craft shoppes, antiques and Kentucky mementos.

**HEADLEY-WHITNEY MUSEUM** — Fine museum of diversified collections, it is the only contemporary collection of its kind open to the public in the United States. The Jeweled Bibelot Collection, Oriental porcelains from the Ming Dynasties, a Shell Grotto and the Art Library offer visitors an exciting tour.

**HOPEMONT, THE JOHN HUNT-MORGAN HOUSE** — Built in 1814 for Kentucky's first millionaire, John Wesley Hunt. The Mansion is a Federal masterpiece; cantilevered staircase, formal gardens, walled courtyard and a collection of furniture, portraits and porcelains.

**KEENELAND** — Popular Thoroughbred race course where the genteel tradition of "racing as it was meant to be," is played out in the Spring and Fall.

**KENTUCKY HORSE PARK** — Unique in the world, 1,032 acres of exhibits and events, museums and demonstrations and, of course, horses!

**LOUDON HOUSE** — A Gothic villa which is now the home of the Lexington Art League. The house features a gallery and artist studio tours.

**MARY TODD LINCOLN HOUSE** — Girlhood home to Mary Todd, Abraham Lincoln's wife. This home is the first shrine to a first lady in America. The house was built in 1803.

**SPENDTHRIFT** — Tour the world famous horse farm, Training Center and watch Thoroughbreds work out on the covered track. See the award-winning multimedia presentation, "To Race the Wind."

**THE LEXINGTON CEMETERY** — Chartered in 1848, this historic cemetery is known as one of the most beautiful cemeteries in America. Located on West Main Street, the beautifully landscaped grounds

highlight two lakes with water fowl and goldfish, a sunken garden, and other gardens. Some notables buried in the cemetery include Henry Clay, General John Hunt Morgan, Adolph Rupp, Vice President John C. Breckinridge, and Author James Lane Allen.

**THE RED MILE** — Historic harness track where trotters and pacers test their speed on the "world's fastest harness track." Spring and Fall racing.

**TRANSYLVANIA UNIVERSITY** — Oldest institution of higher learning in the West features Old Morrison Hall, a classic Greek Revival style building that is a national historic landmark.

**TRIANGLE PARK** — Favorite downtown gathering spot for "Lunch with the Arts," or a midnight stroll. Unique water steps are the focal point for this tree-lined park, built through the generosity of private citizens.

**UNIVERSITY OF KENTUCKY** — With an enrollment of 26,000 the University of Kentucky has a national and international reputation in such diverse fields as medicine, sociology, political science, equine research and agriculture.

**VICTORIAN SQUARE** — A complete renovation of a downtown city block brought back to its former splendor so that today its elegant facade hosts the finest in retail shops and restaurants.

**WAVELAND STATE HISTORIC SITE** — A tour of historic homes would not be complete without visiting the Waveland State Historic Site, located at 225 Higbee Mill Road. Exemplifying a true antebellum home, Waveland was built in 1847 by Joseph Bryan, a grand nephew of Daniel Boone. The grounds boast an impressive array of nineteenth century dependencies, including brick servants' quarters, an ice house, and a smokehouse.

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# Epidemiology of Sudden Infant Death Syndrome (SIDS) for Kentucky Infants Born in 1990: Maternal, Prenatal, and Perinatal Risk Factors

Darshak M. Sanghavi

DMS received his BA in Biology and American Politics from Harvard University and is now a fourth year medical student at the Johns Hopkins University School of Medicine.

*Using state vital statistics data for infants born to Kentucky residents in 1990, a nonconcurrent prospective study design was used to evaluate various risk factors for infant mortality from Sudden Infant Death Syndrome (SIDS). For comparison, an identical analysis was performed for infant mortality from all causes combined, including SIDS. The following factors were considered as potential risks: infant low birthweight, maternal age at delivery, maternal education, maternal cigarette and alcohol use during pregnancy, prenatal care, maternal race, method of delivery, premature birth, sex of the child, and multiple (twin or more) birth.*

*A categorical analysis was used to calculate an adjusted relative risk for each potentially significant ( $p < 0.10$ ) risk factor. Potentially significant*

*adjusted relative risks for SIDS are maternal age under 20 ( $1.73, p \leq 0.08$ ), maternal years of education ( $0.80$  for one year,  $p < 0.01$ ), maternal cigarette use ( $1.92$  for one pack per day,  $p < 0.01$ ), Cesarean delivery ( $2.09, p \leq 0.01$ ), and premature birth ( $1.76, p \leq 0.08$ ). Potentially significant adjusted relative risks for infant death from all causes are low birthweight ( $5.93, p < 0.01$ ), maternal age over 35 ( $1.54, p \leq 0.05$ ), maternal years of education ( $0.94$  for one year,  $p \leq 0.02$ ), marginal prenatal care ( $1.47, p \leq 0.01$ ), premature birth ( $1.47, p < 0.01$ ), and female sex ( $0.82, p \leq 0.05$ ).*

*Given this data, there may be unique risk factors for SIDS. The implications of these findings are discussed.*

Infant death remains a serious public health problem. For 1990, the National Center for Health Statistics reported that 9.2 of every 1,000 American infants died before reaching their first year (defined as "infant mortality" rate).<sup>1</sup> Across the world, 20 countries had better infant mortality records than the US; Japan's rate was the lowest at 4.4 per 1,000.<sup>2</sup> Kentucky fared slightly better than average for the US, with an infant mortality rate of 8.4 per 1,000 in 1990.

SIDS is a major contributor to infant death. The National Institute of Child Health and Human Development (NICHD) suggests a definition of SIDS as "the sudden death of an infant under 1 year of age which remains unexplained after a thorough case investigation, including perform-

ance of a complete autopsy, examination of the death scene, and review of clinical history,"<sup>3</sup> although in practice an autopsy is not always performed. In Kentucky, 19% of the 1990 infant deaths were attributed to SIDS on the death certificate. Nationwide, SIDS causes 14% of total infant deaths, and 40% of infant deaths between the ages of 2 to 12 months are attributable to SIDS.<sup>3</sup>

The pathogenesis of SIDS is poorly understood. Numerous epidemiological studies have attempted to classify relevant risk factors, so that prevention might be possible. A host of risk factors have been proposed, including infant sleeping in prone position,<sup>4</sup> infant staphylococcal infection,<sup>5</sup> Black race (since African Americans have a disproportionately high prevalence of

SIDS),<sup>6</sup> and household smoking during infant gestation.<sup>7</sup>

The present study was undertaken to confirm risk factors for SIDS in Kentucky and to try to identify new ones. A comparison to risks of death from all causes combined was concurrently performed to provide a baseline for comparison.

### Study Design

A nonconcurrent prospective study design was used. At the time of the study, the latest complete vital statistics were available for infants born in 1990. Raw data was retrieved from Kentucky resident birth and death certificates for all infants. These certificates are maintained by the Vital Statistics Department of the Cabinet for Human Resources. Fifty-four thousand forty-one births were recorded for Kentucky residents in 1990. Every resident birth in Kentucky was followed for a period of 1 year after birth. Of the recorded births, 433 infants died within 1 year. Of these 433 deaths, 70 were attributed to SIDS (ICD-9 code 798.0) on the death certificate. (It is important to distinguish these figures from 1990 infant mortality; the latter includes only infants who *died* in 1990, but this study includes only infants *born* in 1990.)

If a birth certificate was incomplete regarding any of the tested risk factors, that particular infant was omitted from the analysis. After this selection, a total of 41,598 infants remained for the analysis. The Statistical Analysis System (SAS) was used to perform a CATMOD categorical analysis of outcome (life or death) based on specified risk factors.<sup>8</sup> Using the database of 41,598 births, infants who died were compared to infants who survived. Risk factors were defined and control settings were specified (Table 1). Since the categorical analysis for all risk factors was performed simultaneously, an adjusted relative risk was calculated for each significant risk factor. The analysis was performed twice: first for infant death from all causes combined, and then for infant death due only to SIDS. P-values for each risk factor were calculated, and an adjusted relative risk with confidence intervals was computed for each risk factor with  $p < 0.10$ . (Table 2 and Fig 1). Significance at the  $p \leq 0.10$  and  $p \leq 0.05$  levels is indicated on the table.

For example, an infant delivered by Cesarean section has a  $2.09 \pm 0.58$  times greater chance of dying of SIDS than an infant delivered vaginally. Since  $p < 0.01$ , there is a 99% chance this represents an elevated risk. An advantage of

**Table 1:** Risk factor definition and control settings for categorical analysis

Risk Factor	Definition	Control Setting for Adjusted Relative Risk Calculation
Low Birthweight	Infant weight less than 2500 grams	Weight over 2500 grams
Mother's Age	Age was partitioned into 3 categories: <20, between 20-35, and >35 years of childbirth	Between 20-35 years old
Mother's Education	Number of years of education	No education. Therefore relative risk <1 means that education is protective
Maternal Cigarette and Alcohol Use	Cigarette use was rounded to quarters-per-day, and alcohol use was rounded to drinks per day (during pregnancy)	No alcohol or cigarette use during pregnancy
Prenatal Care	Kessner Index was used to partition into adequate, marginal, or inadequate care. <sup>13</sup>	Adequate care
Mother's Race	Categorized as either Black, White, or Other	White
Method of Delivery	Classified as either vaginal or Cesarean	Vaginal
Multiple Birth	Birth was classified as either single or multiple (twins, triplets, etc.)	Single
Prematurity	Gestational age was calculated by difference between birthdate and date of mother's last menstrual period. Infants <37 weeks old are premature	Infants $\geq 37$ weeks old at birth
Sex of Child	Male or Female	Male

this categorical analysis is that each risk factor is adjusted for all the others. Therefore, for example, low birthweight is not confounding the relative risk of C-section delivery. Additionally, a relative risk that is less than 1.0 implies that that particular trait is protective. Therefore, female infants have a  $0.82 \pm 0.21$  relative risk of infant death from any cause, implying that female infants are less prone to infant death.

### Results

Numerical results of the categorical analysis are shown in Table 2, and demonstrated graphically in Fig 1. Potentially significant adjusted relative risks of SIDS are maternal age under 20 (1.73,  $p \leq 0.08$ ), maternal years of education (0.80 for one year,  $p < 0.01$ ), maternal cigarette use (1.92



## SIDS in Kentucky

**Table 2.** Categorical risk analysis of total infant death and SIDS for infants born to Kentucky residents in 1990.

Risk Factor	Total Infant Death				Sudden Infant Death Syndrome (SIDS) Deaths			
	p Value	Significant ( $p < 0.10$ )?	Significant ( $p < 0.05$ )?	Adjusted Relative Risk	p Value	Significant ( $p < 0.10$ )?	Significant ( $p < 0.05$ )?	Adjusted Relative Risk
Low birthweight	<0.01	Yes	Yes	$5.93 \pm 0.26$	0.99	No	No	
Mother's Age >35	0.05	Yes	Yes	$1.54 \pm 0.44$	0.74	No	No	
Mother's Age <20	0.88	No	No		0.08	Yes	No	$1.73 \pm 0.64$
Mother's Education, per year of school	0.02	Yes	Yes	$0.94 \pm 0.05$	<0.01	Yes	Yes	$0.80 \pm 0.14$
Maternal Ciga- rette Use, per pack per day	0.61	No	No		<0.01	Yes	Yes	$1.92 \pm 0.45$
Maternal Alco- hol Use, per drink per day	0.96	No	No		0.99	No	No	
Marginal Pre- natal Care	<0.01	Yes	Yes	$1.47 \pm 0.24$	0.41	No	No	
Inadequate Pre- natal Care	0.11	No	No		0.35	No	No	
Race Black Mother	0.35	No	No		0.48	No	No	
Race Other Mother	0.92	No	No		0.99	No	No	
Cesarean Deliv- ery	0.18	No	No		0.01	Yes	Yes	$2.09 \pm 0.58$
Multiple Birth	0.58	No	No		0.20	No	No	
Premature Birth	<0.01	Yes	Yes	$1.47 \pm 0.24$	0.08	Yes	No	$1.76 \pm 0.63$
Female Child	0.05	Yes	Yes	$0.82 \pm 0.21$	0.19	No	No	

for one pack per day,  $p < 0.01$ ), Cesarean delivery ( $2.09$ ,  $p \leq 0.01$ ), and premature birth ( $1.76$ ,  $p \leq 0.08$ ). Potentially significant adjusted relative risks of infant death from all causes are low birthweight ( $5.93$ ,  $p < 0.01$ ), maternal age over 35 ( $1.54$ ,  $p \leq 0.05$ ), maternal years of education ( $0.94$  for one year,  $p \leq 0.02$ ), marginal prenatal care ( $1.47$ ,  $p \leq 0.01$ ), premature birth ( $1.47$ ,  $p < 0.01$ ), and female sex ( $0.82$ ,  $p \leq 0.05$ ).

From a public health perspective, it is useful to classify the possible risks as modifiable or non-modifiable. Encouragingly, many nonmodifiable factors do not appear to influence risk of SIDS death. Female sex of the child ( $p \leq 0.19$ ), multiple birth ( $p \leq 0.20$ ), Black race ( $p \leq 0.48$ ), and other (non-Black, nonwhite) race ( $p \leq 0.99$ ) do not significantly affect chance of SIDS. Similarly, risk of infant death from all causes is not significantly affected by multiple birth ( $p \leq 0.58$ ), Black race ( $p \leq 0.35$ ), and other race ( $p \leq 0.92$ ). However, a female infant is less likely to die ( $p \leq 0.05$ ).

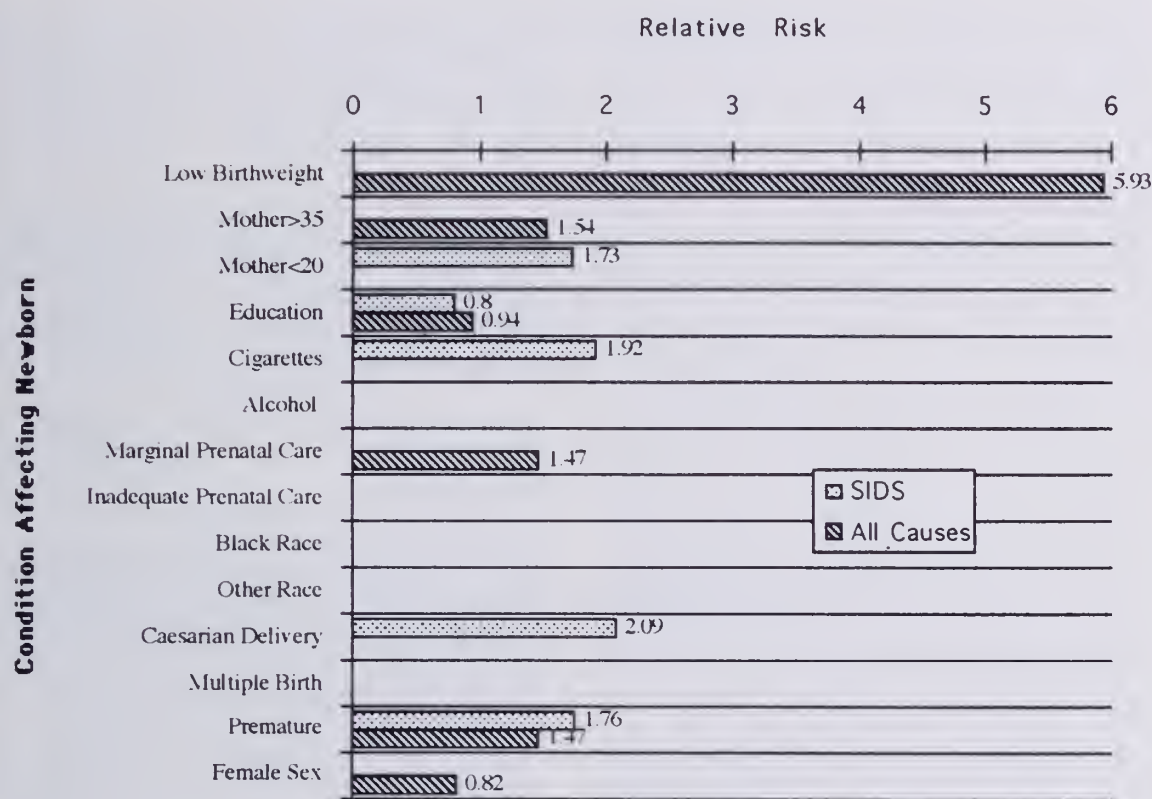
Modifiable risks for SIDS, such as precocious

pregnancy, maternal education, and maternal cigarette use, can be targeted by public health programs. (The issue of Cesarean delivery is discussed below.) Similarly programs can address modifiable risks of infant death from all causes, such as late maternity, poor prenatal care, and maternal education. From the data, it is unclear whether premature birth or low birthweight are modifiable or nonmodifiable.

### Discussion

The previous NICHD report is partially confirmed by these results, which show risk of SIDS elevated by maternal cigarette smoking ( $p < 0.01$ ) and probably by younger age of the mother ( $p < 0.08$ ). However, this study does not confirm NICHD's findings that low birthweight, male sex of the infant, and prenatal care have significant effect on SIDS.<sup>3</sup>

The findings do not show that race is an independent risk factor for SIDS. Instead, it is pos-



**Fig 1 — Potentially Significant ( $p \leq 0.10$ ) Adjusted Relative Risks for Infant Mortality from SIDS and All Causes for Kentucky Infants Born in 1990.**

Note: A blank lane indicates that that particular adjusted relative risk has  $p > 0.10$  and is not classified as potentially significant.

sible that the high prevalence of SIDS in Black infants is due to socioeconomic conditions and education. This recapitulates the findings of a New Zealand study which showed that the higher prevalence of SIDS in the underprivileged Maori population was due not to race but to economic and social factors.<sup>9</sup> The powerful correlation between infant death and maternal education emphasizes that any prevention program must consider a mother's social and economic environment. Since the data do not show that poor prenatal care significantly increases the risk of SIDS, increasing existing prenatal care may not be the simple solution to preventing SIDS.

An unusual finding is that mothers with marginal prenatal care have higher risks of combined-cause infant death than mothers with inadequate prenatal care. A more complete assessment of prenatal care on birth certificates may be helpful in clarifying this finding. The value of prenatal

care in preventing SIDS should not be discarded since good prenatal care may, for example, reduce maternal smoking and therefore reduce risk of SIDS.

The relation of Cesarean delivery to SIDS merits further research. A previous study found no relation between induced labor and subsequent risk of SIDS.<sup>10</sup> Furthermore, after correcting for gestational age, NICHD found no significant difference between SIDS and non-SIDS infant Apgar scores.<sup>3</sup> Thus delayed childbirth or fetal distress may not explain increased Cesarean risk. In addition, death from hyaline membrane disease (Respiratory Distress Syndrome, RDS), which is related to Cesarean delivery,<sup>11</sup> may be commonly misclassified as SIDS.

Finally, the data demonstrate some discrepancies in risk factors for total infant death and SIDS. The relative risks of maternal age, maternal smoking, prenatal care, infant's sex, and Cesarean



## SIDS in Kentucky

delivery are different between SIDS and combined-cause infant death. This suggests that SIDS is a distinct disease process with distinct risk factors.

Studies depending on vital statistics data have two important strengths. First, a large sample size can be obtained, and the sample furnishes data that can be applied specifically to Kentucky. Second, this analysis minimizes observer bias. Since the birth certificate data is completed in advance of death, a prospective study design is possible.

There are also some limitations. First, the cause of death is taken directly from death certificates. Since cause of infant death is sometimes misdiagnosed without autopsy,<sup>12</sup> future studies might be improved with larger sample and a screen for autopsy. Second, this analysis assumes that data omission from birth and death certificates is evenly distributed. Third, nonfatal birth outcomes are not included in this analysis. For example, maternal alcohol use during pregnancy is not a significant predictor of infant death but obviously causes Fetal Alcohol Syndrome.

In summary, epidemiological risk factor studies can be instructive to care givers and policy makers. Thorough completion on birth and death certificates is an important prerequisite to these studies. In the future, more complete birth and death certificates for infants (including infant feeding habits, paternal health habits, familial disease, etc) would provide better data to study infant mortality risks.

ACKNOWLEDGMENTS: The author would like to thank Dr Leon Gordis of the Johns Hopkins School of Hygiene and Public Health and Dr Reginald Finger of the KY State Division of Epidemiology.

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# Benign Schwannoma of the Small Intestine: An Unusual Cause of Gastrointestinal Bleeding

Steven H. Gallo, MD; Michael A. Sagatelian, MD

*Neurogenic tumors of the small intestine are exceedingly rare accounting for less than 1% of all neoplasms involving the gastrointestinal (GI) tract. These lesions may remain clinically silent for years, but usually manifest by the 5th or 6th decade of life. Occult transient hemorrhage from the GI tract interspersed by relatively long asymptomatic periods is the most common presentation. This report describes a case of a patient with a solitary benign duodenal schwannoma and no prior symptoms presenting as an acute life-threatening upper GI hemorrhage. Small bowel tumors of neurogenic origin represent an unusual cause of GI hemorrhage. The diagnosis should be considered in such cases to insure appropriate and timely management.*

**T**umors of the small bowel are uncommon lesions comprising approximately 6% of all gastrointestinal (GI) neoplasms<sup>1,2</sup> with less than 10% of these being of neurogenic origin.<sup>3</sup> The diagnosis may often be delayed due to the vague and nonspecific symptoms that these neoplasms produce. Often, these tumors become clinically apparent only after they produce complications. One of the principal manifestations is bleeding from the GI tract.<sup>2,6</sup> Due to the rarity of such lesions, these tumors often remain unrecognized as a potential source of gastrointestinal bleeding. It is important for the clinician to at least consider such tumors in patients who present with GI hemorrhage. We report a case of a patient who presented with acute upper GI tract bleeding in whom a solitary benign schwannoma of the duodenum was discovered as the sentinel lesion.

## Case Report

A 57-year-old white female with a history of hypothyroidism was admitted to the hospital because of gastrointestinal bleeding. She was otherwise well until the day prior to admission when she developed the onset of hematochezia. Stools were loose, grossly bloody, and occurred 4 to 5 times throughout the day. There was no associated abdominal pain or cramping. She noted progressive malaise, lethargy, and associated anorexia. There was no fever or sweats. The morning of admission she suffered a syncopal episode at home.

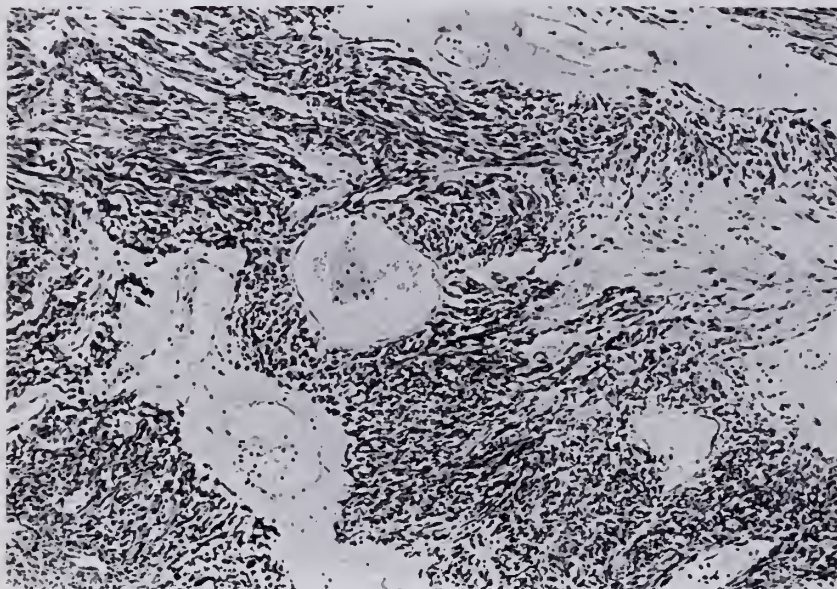
At presentation, she denied any prior history of hematemesis, melena, or hematochezia. She admitted to rare aspirin ingestion and had taken two tablets on the day prior to admission. She gave no history of cigarette smoking and denied ingestion of alcohol. There was no prior history of peptic ulcer disease, inflammatory bowel disease, anemia, or weight loss. A family history was not contributory.

On examination, the patient appeared pale and listless. The temperature was 37.5 C, the pulse was 115, and the blood pressure was 98/70 mm Hg. The lungs were clear. The heart was tachycardiac with a regular rhythm. No murmur was heard. The abdominal examination was benign; there was no tenderness, organomegaly, masses, or bruits. The bowel sounds were hyperactive. Rectal exam showed normal sphincter tone with burgundy unformed stool which was positive for occult blood. The remainder of the physical examination was unremarkable. Laboratory data revealed a hemoglobin level of 6.0 g/dl and a hematocrit of 18.1%. The WBC count was 16,700 with

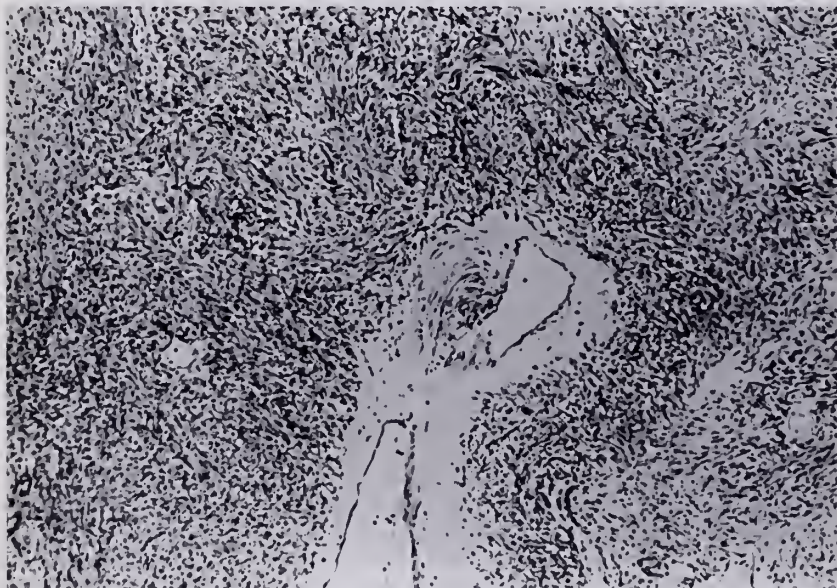
*From the University of Louisville School of Medicine, Department of Medicine, Division of Gastroenterology/Hepatology, Louisville, KY.*



## Benign Schwannoma of the Small Intestine



**Fig 1** — Photomicrograph of tumor demonstrating Antoni A (compact cellular area, foreground) and Antoni B (loosely arranged myxoid area, top) regions characteristic of benign schwannoma (hematoxylin and eosin,  $\times 250$ ).



**Fig 2** — Photomicrograph of lesion revealing prominent blood vessels characterized by thick fibrous walls. Note fascicles of spindle cells creating distinctive palisading pattern (hematoxylin and eosin,  $\times 250$ ).

84% PMNs, 10% lymphocytes, and 6% monocytes. Red blood cell indices were normal. The platelet count was 278,000. The prothrombin time was 12.8 seconds (control, 12.0 seconds) and the partial thromboplastin time was 25.2 seconds (control, 28.5 seconds). The blood urea nitrogen was

29 mg/dl (normal, 7-18 mg/dl) and the creatinine 0.5 mg/dl (normal, 0.5-1.2 mg/dl). The electrolytes were within normal limits. The remainder of the patient's serum chemistries were unremarkable. An x-ray film of the abdomen revealed a non-specific gas pattern with no free air.

Transfusions of packed red blood cells were administered and the patient was empirically started on an intravenous H<sub>2</sub>-blocker. An EGD was performed revealing active bleeding in the 2nd portion of the duodenum. However, a specific lesion could not be localized. A visceral angiogram revealed active extravasation from a branch of the superior pancreaticoduodenal artery. This was initially interpreted as an arteriovenous malformation (AVM) and gelfoam embolization was attempted without success. Because of persistent GI bleeding, an exploratory laparotomy was performed which demonstrated a 2 cm tumor protruding from the anterior wall of the 2nd portion of the duodenum. Resection of the tumor with primary closure of the duodenum was performed without complication. Histologic examination revealed a benign stromal tumor consistent with a solitary schwannoma (Figs 1 and 2). Immunohistochemical staining substantiated its neurogenic origin.

## Discussion

Primary tumors of the small intestine are uncommon neoplasms accounting for only a small proportion of all gastrointestinal tumors.<sup>1,2,5,6</sup> Small bowel tumors of neurogenic origin are exceedingly rare comprising only 3.2% to 6.4% of the total.<sup>4</sup> Their presence has been associated in up to 25% of patients with von Recklinghausen's disease,<sup>7,8</sup> although they may occur in the absence of cutaneous neurofibromatosis. They may be unifocal or multiple,<sup>9</sup> but the latter is more likely if generalized neurofibromatosis is present.<sup>4</sup> Solitary neurogenic tumors are histologically similar to those found in von Recklinghausen's disease. These lesions can be found throughout the small intestine and, in one large series, have been reported to occur slightly more frequently in the ileum.<sup>3</sup> Subsequent reports have noted equal distribution of these tumors in all segments of the small bowel.<sup>1,4</sup>

Neurogenic tumors of the small intestine are thought to arise from Auerbach's plexus, between the inner circular and outer longitudinal layers of smooth muscle.<sup>9</sup> They may project intraluminally as found in our patient, but more often ex-



tend into the serosa along the antimesenteric border.<sup>4,9</sup> Histologically, they have been classified as (1) neurofibromas, the most common type and the type which is found in von Recklinghausen's disease, (2) neurilemmoma, classically known as the schwannoma, and (3) rarer types which include the paraganglioma and the ganglioneuroma.<sup>1,9</sup> The majority of these tumors are benign,<sup>10,11</sup> although malignant degeneration has been reported to occur infrequently.<sup>4,11,12</sup>

Histologically, the tumor from our patient displayed sheets and fascicles of spindle cells arranged in a vague palisading pattern characteristic of a benign stromal tumor. The lesion also demonstrated the typical microscopic features of a neurilemmoma including Antoni A and B regions (Fig 1), and multiple small, thick-walled blood vessels (Fig 2).<sup>13</sup>

The cell of origin of stromal tumors may be determined using various immunohistochemical markers. These include desmin, vimentin, glial fibrillary acidic protein (GFAP), and S-100 protein.<sup>14,16</sup> Although the origin of stromal tumors can sometimes be unclear based solely on light microscopic findings, the presence of S-100 protein immunoreactivity suggests neural differentiation.<sup>14,15</sup> Immunoperoxidase staining demonstrated that the tumor contained S-100 protein and vimentin while smooth muscle markers were negative. Thus, we concluded that our patient had a stromal tumor of neural origin consistent with a benign schwannoma.

Neurogenic tumors of the gastrointestinal tract usually do not become clinically apparent unless there is either necrosis of the tumor with hemorrhage or intraluminal extension. Patients can often harbor these lesions for years without symptoms. If symptoms manifest, usually in the fifth or sixth decade of life,<sup>5</sup> they are often nonspecific. Vague complaints such as dyspepsia, malaise, anorexia, or intermittent diffuse abdominal discomfort are frequently offered. These can be easily dismissed due to the lack of physical findings and the diagnosis may often elude the examining clinician. Approximately half of benign lesions remain asymptomatic and are discovered only at autopsy.<sup>6</sup>

Gastrointestinal hemorrhage is the most common presenting clinical manifestation occurring in 36% to 48% of cases reported.<sup>4,5,8</sup> Slow progressive tumor growth results in stretching and erosion of the overlying mucosa.<sup>4,9</sup> Blood loss is usually occult with a microcytic anemia developing over several months to years.<sup>6,17</sup> Intermittent bouts

of melena, hematochezia, or hematemesis can occur followed by relatively long asymptomatic periods.<sup>4</sup> In one review of 32 patients with small intestinal neurogenic tumors, the average time for diagnosis was 3 years from the onset of symptoms.<sup>18</sup> Our patient was unique in that she presented with an acute, massive, life-threatening upper gastrointestinal hemorrhage with no prior symptoms. This presentation is atypical as most acute hemorrhagic episodes are usually mild and nonfatal.<sup>4</sup>

Symptoms of intestinal obstruction are the second most frequent clinical presentation,<sup>1,9</sup> and are often the result of intussusception or from compression of the intestine by the tumor itself.<sup>3,4</sup> The obstruction produced by these lesions can be partial and intermittent.<sup>3</sup> Complaints of abdominal pain may be nebulous and are often attributed to functional disorders of the GI tract. Rarely a palpable abdominal mass is found, but usually is a result of a dilated small bowel loop rather than the tumor itself.<sup>6</sup> Rare instances of perforation have been reported.<sup>19,20</sup>

As with other tumors of the small bowel, the diagnosis of these lesions is usually difficult. Routine contrast radiography may aid in the diagnosis provided there is intraluminal extension of the tumor, but such studies are negative in greater than 50% of cases.<sup>10</sup> The use of enteroclysis is likely more sensitive and, in one series, was successful in detecting 48 small bowel lesions previously missed by routine upper gastrointestinal series with small bowel follow through.<sup>21</sup> Barium enema can occasionally reveal neoplastic involvement of the terminal ileum via reflux of contrast through the ileocecal valve.<sup>6</sup> The use of selective abdominal angiography has been advocated by some authors as the next method of choice if conventional radiography fails,<sup>10</sup> and will often identify vascular lesions or those with active bleeding greater than 1 ml/minute.<sup>6</sup> Isotopically tagged red blood cell scans may be helpful in localizing lesions with slower bleeding rates.<sup>1,6,17</sup> Flexible fiberoptic endoscopy may be useful in demonstrating the tumor provided it is within reach of the instrument.<sup>4</sup> More recently, small bowel enteroscopy has been shown to be of particular value in identifying these lesions<sup>22</sup> and may eventually prove to be the diagnostic modality of choice in evaluating patients suspected of harboring such tumors.

Once localized, several therapeutic approaches may be utilized. Initial control of significant hemorrhage may be achieved through the



## Benign Schwannoma of the Small Intestine

use of embolic strategies during angiography. Endoscopic polypectomy and electrocoagulation of the tumor have been proposed as a relatively safe means of treatment,<sup>4</sup> if the lesion is within the range of the endoscope. Surgical excision of the offending neoplasm is the most commonly employed form of therapy and currently is the treatment of choice for symptomatic lesions.<sup>2,5,6,8,9</sup> In our patient, active bleeding obscured adequate visualization and did not permit an endoscopic approach. Ultimately, laparotomy with resection was required. In the absence of bleeding, or obstruction, these tumors should be removed to confirm the diagnosis and to exclude the presence of other, more serious malignant neoplasms.<sup>4</sup>

## Summary

Neurogenic tumors of the small bowel are rare lesions which usually become clinically apparent only after they produce complications such as hemorrhage or obstruction. The diagnosis should be entertained in any patient presenting with intermittent crampy abdominal pain, microcytic anemia, or occult blood in the stool with a negative examination of the upper and lower gastrointestinal tract. Although hemorrhagic episodes tend to be mild and nonfatal, the presentation can also be that of acute hemorrhagic shock as was seen in our patient. These lesions require a high degree of suspicion and an aggressive diagnostic approach if life-threatening complications are to be avoided.

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# Bilateral Ectopic Pregnancy

## A Case Report

Dorel Abramovici, MD; F. Andrew Morfesis, MD; Syed Ally, MD; NR Bathija, MD

*Bilateral ectopic pregnancy is a rare phenomenon. It has been 76 years since the first published report of a case of bilateral ectopic pregnancy.<sup>1</sup> Since then about 200 cases have been reported in the literature; we report a case here.*

The patient is a 40-year-old gravida 2, para 1, who had irregular menstrual periods. The history of the patient is significant for absence of pelvic inflammatory disease or IUD; a cesarean section in 1989 was done for fetal distress. In 1992, the patient had a laparoscopy for chronic pelvic pain and infertility. No pelvic pathology was found and both tubes were found to be patent after dye instillation.

One year later, after several irregular periods the patient had a positive urine pregnancy test and a Beta HCG of 269 M.I.U./ml. Vaginal ultrasound revealed no intrauterine pregnancy or any other pathology. Three days after the initial test, Beta HCG was 162 M.I.U./ml and the patient experienced an onset of vaginal bleeding and abdominal pain. On a repeat ultrasound examination, the patient had fluid in the cul-de-sac but no abdominal masses. D&C revealed decidual tissue with no chorionic villi. Laparoscopy was performed to rule out ectopic pregnancy. The patient was found to have 50 cc of blood in the cul-de-sac, and bilateral 2 × 2 cm bluish enlargements of the isthmic areas of both tubes. Exploratory laparotomy and bilateral linear salpingostomy followed without postoperative complications.

Chorionic villi were identified on microscopic examination from the tissue specimen from both left and right tubes and a diagnosis of

bilateral ectopic pregnancy was thereby confirmed.

### Discussion

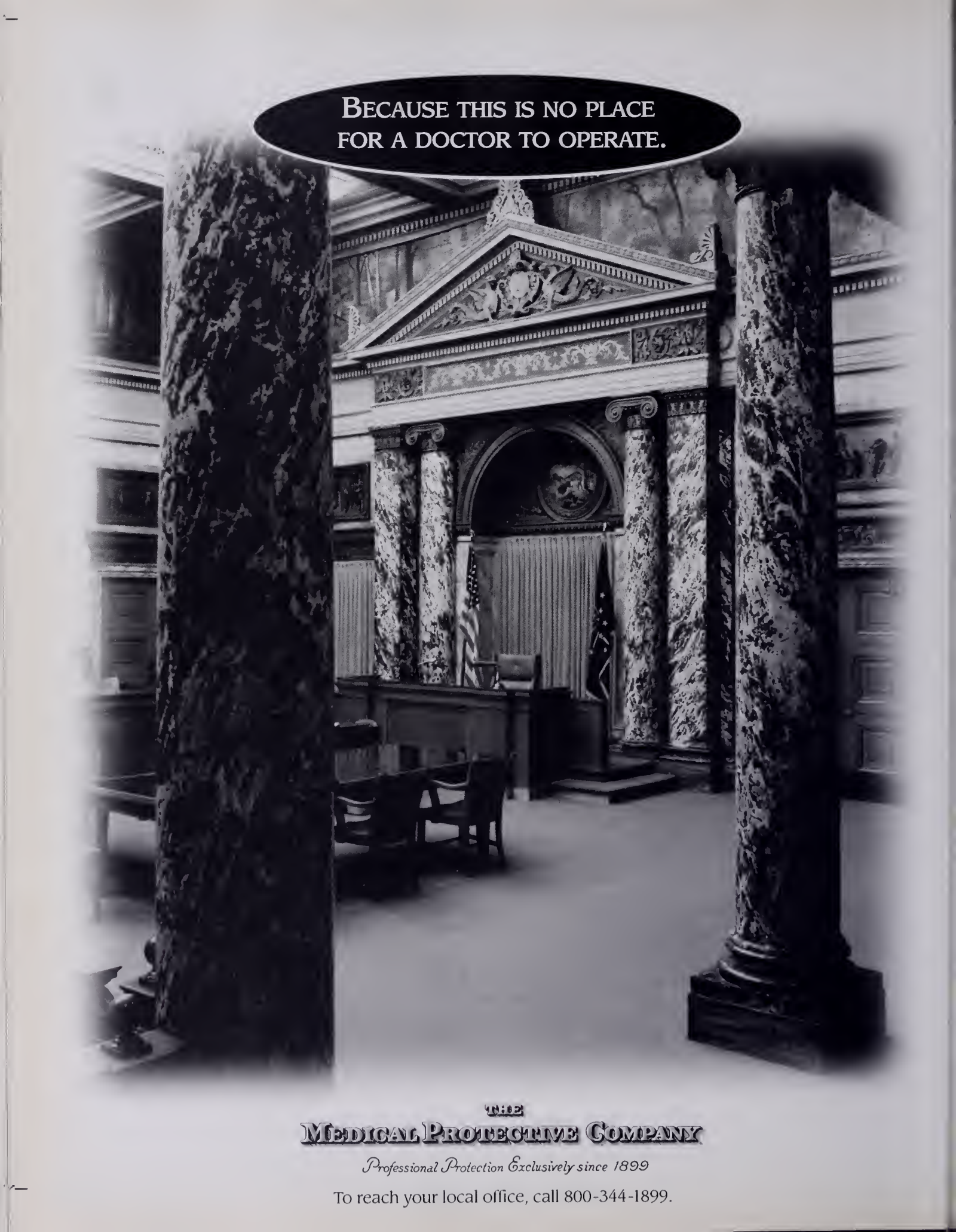
Seventy-six years ago the *Southern Medical Journal* published its first case of reported bilateral ectopic pregnancy.<sup>1</sup> Since then approximately 200 more cases have been documented both in natural and in vitro fertilization cycles.<sup>2</sup> Our case fulfills the criterion set by Norris,<sup>3</sup> which requires demonstration of chorionic villi in each fallopian tube in order to establish the diagnosis of bilateral ectopic pregnancy. Grossly, the size of the implants could be consistent with simultaneous implantation or a possible "old" and a recent ectopic pregnancy. There is no way to rule out this possibility. In fact the low value of Beta HCG suggests that perhaps only one ectopic is producing HCG. The pathology report could not date the specimen, and both villi from the left and right tube showed similar development. Unfortunately, this case does not shed any light on a possible explanation of this uncommon entity, the genesis, or the diagnostic and treatment modalities. This case is presented as an addition to previous accounts of these events.

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# Release of Patient Medical Records

**P**hysicians and their office staffs are frequently presented with questions about the ownership, release, and retention of patients' records. This paper was originally prepared in 1991, but has been updated by Charles J. Cronan IV, legal counsel, with the assistance of Lissa Wathen and Martha J. Hasselbacher, attorneys with the law firm of Stites & Harbison, to include aspects of HB250 enacted by the 1994 Kentucky General Assembly.

## I. Ownership of Medical Records

Original medical records are the physical property of the physician or the health care facility that provides care to the patient. However, the physician or facility is not considered to "own" the information contained in the records. It is the position of the American Medical Record Association, the AMA's Council on Ethical and Judicial Affairs, and most courts that patients have a right of access to the information in their medical records, except in limited circumstances. The original record and originals of any reports in the record need not and should not be surrendered.

## II. Content of Medical Records

The physician has discretion as to what information and documents are included in the patient's medical record file. Generally, it is a good idea to include only such things as the medical history, updated medical chart, reports of consultants, laboratory reports, and the like in the medical file. Billing records and other "business" aspects of the patient's care should be separately maintained. However, if separate files are maintained, in responding to a subpoena or request for records, care should be taken to include all the items specifically requested.

Care should also be taken to avoid uncomplimentary comments in the chart. Physician notes may be read by the patient or may become part of a public record if the documents must be produced.

## III. Patient's Right of Access to Records

Given the generally recognized right of access to one's own medical records, health care providers should furnish the patient with a copy

of the record or a summary of its contents when the patient makes such a request. The request should include adequate verification of the requesting patient's identity. Only when a physician makes a reasonable determination that releasing the contents of the medical records to the patient may result in physical or mental harm to the patient or cause physical danger to some third party should the information be withheld by the physician.

KRS 422.317 grants the patient a right to a copy of the patient's medical record. Some federal laws and other state laws have also expressly granted access rights applicable to specific circumstances. For example, the Federal Privacy Act, 45 C.F.R. 5b, recognizes an individual's general right of access to medical records maintained by the Department for Health and Human Services and any of its agencies, including VA Hospitals and Medicare and Medicaid intermediaries and carriers. Kentucky Regulation, 908 KAR 3:010, expressly provides for a mentally ill or retarded patient to have access to that patient's entire record upon written request, unless the provider provides written documentation of specific reasons for the refusal. It is uncertain how this law will interface with the more general law which appears to give the patient an absolute right to those records.

## IV. Charges for Copies

KRS 422.317 provides that:

Upon a patient's written request, . . . a health care provider shall provide, without charge to the patient, a copy of the patient's medical record. A copying fee, not to exceed one dollar (\$1.00) per page, may be charged by the health care provider for furnishing a second copy of the patient's medical record upon request either by the patient or the patient's attorney or the patient's authorized representative.

This law became effective on July 15, 1994. During the same session, the General Assembly also enacted a bill which revised the Worker's Compensation Act regarding access to and copies



## Release of Medical Records

of health records. The new section of the Worker's Compensation Act provides that "Any medical provider shall charge only its customary fee for photocopying requested documents. However, in no event shall a photocopying fee of a medical provider or photocopying service exceed fifty cents (\$.50) per page." This same section also provides that "there shall be no charge for review of any records of a medical provider during regular business hours, by any party who is authorized to review the records and who requests a review pursuant to this chapter." KRS 342.035(7).

These statutes have already generated numerous questions about the intended scope and actual extent of their requirements, and the effect of the different charge limitations in the two laws. There are presently no administrative regulations or court decisions which interpret these statutes. However, the two laws read together would limit copy charges to a maximum of \$1.00 per page for non-Worker's Compensation related records and \$.50 per page for records sought pursuant to a Worker's Compensation claim. A patient may use the first free request for Worker's Compensation records. The law does not address mailing costs or storage retrieval fees, which can probably be passed on to the person requesting the records as long as these charges are distinguished from the amount charged for copying.

Where opinions or impressions have been recorded incidental to the patient's care, the opinions should not be excluded or withheld on the basis that additional compensation has not been tendered for your expert medical opinion. Again, the rationale is that the opinion was expressed incidental to care. This is in contrast with the "second opinion" discussed below.

### V. Refusal in View of Unpaid Bill

The AMA's Council on Ethical and Judicial Affairs has stated that it is unethical conduct for a physician to withhold the release of a patient's medical record because the patient has an outstanding balance with the provider. This does not address the situation where a patient consults a physician solely for a "second opinion." In cases where the opinion, itself, is the service sought and rendered, it may be appropriate to condition release of the opinion on prior payment.

### VI. Parties Who May Request Access

A competent adult patient may request his or her own records. In the case of minor or incompetent patients, the parent or the legal guardian of the patient may request the records on the

patient's behalf. If the minor is a child of divorced parents, the custodial parent is responsible for health care. If necessary to determine which parent has custodial authority, a copy of the final court ordered settlement decree explaining custody rights can be requested for the file. If the patient is deceased, the personal representative of the estate may request the records.

Although there are no regulations to provide guidance, the parent or legal guardian of the patient is probably entitled to the free copy when the request is made on behalf of a minor or incompetent patient. This may not be true for the personal representative of the estate if the patient is deceased.

### VII. Release to Third Parties

A valid authorization or release from the patient should accompany any request to release information from the patient's medical record to third parties, including the patient's attorney. The release does not have to be notarized. Ideally, the release should contain:

1. The patient's full name, address, and date of birth;
2. The name and address of the provider who is to release the records;
3. The individual or entity to which the record is to be released;
4. The specific information being requested;
5. The date the release is signed; and
6. The signature of the patient or the patient's legal representative.

There should be no disclosure beyond the scope of the information authorized for release and no disclosure of the same information to anyone other than the recipient named in the release. See paragraph XIV for special requirements pertaining to the disclosure of HIV test results.

### VIII. Special Considerations for Psychological or Substance Abuse and Sexually Transmitted Disease Records

As noted in Paragraph VII above, the patient's authorization should include the specific information to be released. This is particularly true when psychological or psychiatric records, which are privileged under Kentucky law, are included in the patient's file, and when drug or alcohol treatment records from federally supported programs are included. KRS 319.111; KRS 421.215; 42 C.F.R. 2. If these records are to be released, the authorization must mention these areas specifically rather than attempting to in-

clude them within the scope of an authorization to release "all the patient's records," or some similar general language. Similarly, records containing reference to sexually transmitted diseases should not be released without specific authorization. KRS 214.420. See the discussion in Paragraph XIV pertaining to special procedures which must be followed in releasing information pertaining to positive HIV test results.

### **IX. Release to Health Insurers**

Generally, patients have authorized third party payors to obtain copies of their medical records as a condition of their participation in the insurance program. Nevertheless, it would be appropriate to request that an insurer send a copy of the authorization so that the treating provider can keep this copy in the patient's medical file. A general rule would be to confine the release to information related to the particular claim for coverage.

In contracting with third party providers, physicians are often asked to agree to produce medical information about their patients or to make their records available for inspection by the third party. The physician should always seek assurances in the contract that a third party must first obtain the patient's written consent to such disclosures.

### **X. Release of X-Rays**

X-rays are treated like other medical records. A copy should be provided to the patient or to third parties upon proper request when the patient's identity has been verified, but the original need not and should not be surrendered. Although a report summarizing x-rays may be part of the medical records included in a free copy under KRS 422.317, it is probably permissible to charge the reasonable actual cost of the reproduction of the x-rays themselves although, again, there are no regulations concerning this matter.

### **XI. Release Pursuant to Subpoena**

Generally, a subpoena for production of medical records, also called a "subpoena duces tecum," need not be accompanied by a patient authorization in order to require a subpoenaed provider to release the medical record. When a person has put his or her medical condition in issue as a subject of a lawsuit, a separate authorization for release of the relevant medical records to the parties involved is not generally required. However, the subpoena should be accompanied by a "Notice of Deposition" which indicates that both sides of the relevant litigation will have no-

tice of the records request. It should be noted though, that the special considerations regarding psychiatric, psychological, federal substance abuse program, and sexually transmitted disease records still apply. If these types of records are subpoenaed, a valid patient authorization specifying them should accompany the subpoena. Special rules applicable to court orders which seek the disclosure of HIV test results are discussed in Paragraph XIV.

### **XII. Time Limitations on a Release**

There is no legal requirement that authorizations to release medical records are valid only for a limited amount of time. However, there is one exception when records are requested from a drug or alcohol treatment program that receives federal funding. A federal statute, 42 C.F.R. § 2.31, requires that the release of these kinds of records also include a specific date, event, or condition on which the authorization will terminate. Some health care facilities also have institutional policies under which they will not honor a release beyond a certain period such as sixty (60) days or six (6) months.

### **XIII. Retention of Medical Records**

Health care facilities, including primary care centers, personal care homes, nursing homes, and others are required by the provisions of Kentucky Regulation 902 KAR 20 to maintain medical records for five (5) years following the last treatment or entry. The state Medicaid program also imposes a five (5) year retention period for documentation of all services billed to the state medical assistance program, 907 KAR 1:007. Kentucky law does not prescribe a required retention period for physicians' medical records. Before the decision of the Kentucky Supreme Court in *McCollum v. Sisters of Charity* in October 1990, the ban on medical malpractice suits by competent adults more than five (5) years after an event, strongly suggested a minimum of five (5) year retention for records on adult patients. However, the court in *McCollum* held unconstitutional the five (5) year "cap" on medical malpractice suits. As a result, prudence dictates retention of records on competent adults indefinitely.

In the case of minor patients, the record should be retained until the child reaches the age of nineteen (19). Again, however, because of the *McCollum* decision, it would now be wise to keep them indefinitely, as with the records of adults. The records of mentally incompetent or disabled persons should also be kept indefinitely.



## Release of Medical Records

**XIV. Special Reporting Requirements, Including HIV Test Results**

The generally confidential nature of a patient's medical record yields to the public health interests in certain instances. Kentucky law prescribes by regulation 902 KAR 2:020 that certain diseases are designated as "Reportable Diseases" which must be reported to the local county health department when diagnosed. Some must be reported within twenty-four (24) hours and others within seven (7) days. The reporting requirements include, in addition to certain clinical data, the name and address of the patient. Sexually transmitted diseases may generally be reported using a re-identifiable code number in lieu of the patient's name and address.

Kentucky also has enacted statutes which protect the physician against civil and criminal liability for disclosure of otherwise confidential AIDS information. KRS 311.282 protects a physician who reasonably and in good faith advises a spouse or sex partner of a patient (who has cohabited with the patient for more than a year) that the patient has tested positive for the HIV virus.

Court orders seeking the release of information about HIV test results are effective only if they comply with KRS 214.625(10). The order must specify the persons who may have access to the information, the purpose for which it shall be used, and appropriate prohibitions against further disclosure. When disclosure is made, it must be accompanied by a written statement that:

This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such information without the specific written consent of the person to whom such information pertains, or is otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

[KRS 214.625(10)(e)].

Another example of permitted disclosure occurs when an individual with a seizure condition applies for a driver's license. This individual must present a physician's certification that the condition is controlled by drugs and a physician is shielded from civil and criminal liability when he provides this information in good faith. KRS 186.411.

Similarly, physicians are required to report and are protected from liability for a good faith report of child abuse or neglect. KRS 620.030-050.

**XV. Proposed Federal Legislation**

The Federal government and Congress continue to assess the need for federal guidelines to address the confidentiality of medical records. Recently, a bill was introduced into Congress entitled the Fair Health Information Practices Act of 1995. The bill addresses the need for federal law to protect confidential medical information about a patient in one piece of legislation. The bill recognizes a constitutional right to privacy in health care information. It also recognizes that the improper use of disclosure of personally identifiable health information about an individual may cause significant harm to the interest of the individual and may unfairly affect the ability of the individual to obtain employment, education, insurance, credit, and other necessities. H.R. 435. As presently drafted, the bill's effective date is January 1, 1997, and it would supersede any state law which is inconsistent with any provision of the bill.

The law would create uniform rules governing the use, maintenance, and disclosure of health information which are considered an essential part of health care reform and are necessary to support the computerization of health information. The bill has specific requirements for written releases which mandate that the health care provider be named, that there be a statement of the intended use of the disclosure and that the recipient be described. If the health information is to be disclosed in conjunction with litigation or an administrative hearing to which the protected individual is a party who has placed his or her physical or mental status in issue, no release is required. The bill has a separate procedure for judicial purposes which requires only an attested document by the person seeking the health information, notification of the protected individual and a waiting period of ten (10) days before the records are released.

There are criminal penalties included in the bill. There is also an enforcement section which includes civil actions which may be brought by an aggrieved patient and civil money penalties. The bill also provides for alternative dispute resolution as a means of resolving disputes between patients and health information trustees.

**XVI. Computerization**

An electronic document or communication which is part of or replaces a patient's record will be treated by law in the same manner as an equivalent written document. Care should be taken to safeguard the privacy and integrity of any computer system used to ensure that the confidentiality of these records is maintained.



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**Preparation** — Manuscripts should be typewritten in double spacing throughout, including references, tables, legends, quotations, and acknowledgments. Submit the original and one copy, retaining a copy for proofreading. Ordinarily articles should not exceed 3,000 words in length. Titles should include the words most suitable for indexing the article, should stress the main point, and should be short. A synopsis-abstract must accompany each manuscript. The synopsis should be a factual (not descriptive) summary of the work and should state the problem considered, methods, results and conclusions.

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**References** — References must be typed in double spacing on separate sheets and numbered consecutively as they are cited. They should include (in this order) the authors' names and initials, title of article (and subtitle if any), abbreviated name of journal, year, volume number, inclusive page numbers. Follow the AMA style currently in use, abbreviating the names of journals in the form given in *Index Medicus*. Authors are responsible for reference accuracy.

**Illustrations** — Illustrations must be submitted in duplicate and the sequence number and author's name should appear on the back of each. Legends for illustrations should be typewritten (double-spaced) on a separate sheet. The author will be billed for the cost of reproduction of illustrated material for publication in excess of three average illustrations and/or tables. Illustrations other than the author's will not be accepted for publication unless accompanied by written permission from the original source.

**Editorials and Letters** — Should be written in clear, concise language. Length should be about two pages typed with double spacing. Letters will be published at the discretion of the Editorial Board.

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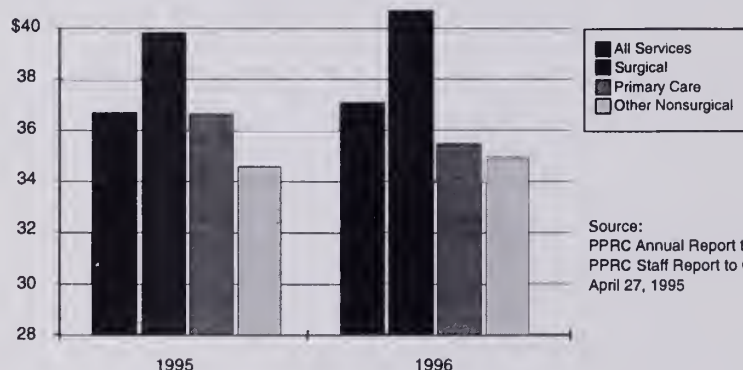
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## Onslaught of inquiries

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### Estimates of Conversion Factors Under One Category of Service Policy Compared to Current Policy, 1995 and Estimated 1996 (dollars)



Source:  
PPRC Annual Report to Congress, 1995  
PPRC Staff Report to Commission  
April 27, 1995

The graph illustrates the inequities in the current Medicare fee schedule created by the policy of multiplying resource-based relative value units (RVUs) by separate dollar conversion factors for surgical, primary care, and other nonsurgical services. The RVUs compare the relative work of each physician service on a common scale. Medicare payments are determined by multiplying the RVUs by the dollar conversion factor (e.g. if a service has an RVU of 2.00, and the conversion factor is \$37.00, Medicare would pay \$74.00 for the service).

The resource based RVUs were intended to pay physicians the same amount for services that involve the same amount of time, mental effort and judgment, technical skill and stress. But separate conversion factors have skewed the payment amounts, violating the fee schedule's basic intent, by paying physicians more per RVU for surgical procedures than for primary care and other nonsurgical services involving the same amount of work. Unless Congress acts to change the formula, the inequities will be even worse in 1996.

The chart compares the 1995 (actual) and 1996 (estimated) conversion factors for surgical procedures, primary care services, and other nonsurgical services with a budget-neutral, single conversion factor for all services. The Physician Payment Review Commission, in its annual report, recommended that Congress require a single conversion factor and a single volume performance standard (VPS) for all services (the VPS determines the annual update for each conversion factor).

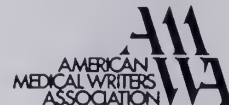


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# Physician, Heal Thyself

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*"One day this month,  
schedule yourself to abide by  
all the generous wellness  
advice you give others.  
Carve that nitch out for your  
own enrichment."*

---

**H**ow many times have you advised a patient to slow down, reduce the stress, decrease responsibilities? How often do you sensitively lean forward to recommend a regular program of exercise to your post-op patient, post-cardiac, post-injury, or chronic stress patient?

During 12 to 15 hour days in which we never stop to eat, we render this advice. During those milliseconds between patients, no less than three people will appear with multiple charts each to check patient problems with you or pass you a phone. Is it any wonder that "sometimes" you pick neither 5:30 AM nor 10:30 PM for your *own* life sustaining, cardiac retaining, stress reduction exercise protocol, but pass altogether?

Can you recall wondering in medical school how that overweight, smoking physician could be taken seriously when advising his patients to lose weight or stop smoking?

Will the dichotomy in our lives be as obvious as we offer advice from our offices burgeoning with more patients, longer hours, and no time for personal growth and replenishment?

Remember the study of rats dropped into a maze with food at the other end. They quickly learned their way to the food, but if the food was removed, they repeated their travels a few times, but then would desist. When *we* deplete our lives of physical, mental, and spiritual replenishment, we compare unfavorably to those rats in the maze! We continue racing through the maze even when the sustenance is removed!

As Stephen R. Covey says repeatedly in *First Things First*, sometimes we are so busy using the saw we fail to stop to sharpen the saw. Oh, there is little doubt that we sharpen our CME saws, but what about our own Continued Mental-Physical-and-Spiritual Enrichment?

There is nothing new about having multiple, urgent demands placed upon our time and skills as a physician. But our western world moves ever faster on the information highways in Cyberspace. Uncertainties regarding the future practice patterns of medicine stimulate many to keep a fast and furious pace and defer changes until we know better what tomorrow may bring. We all have friends by now who were one beat

too slow to respond to new "market" trends, only to be "locked out" one day later. But, of course, we all have friends who were three beats too fast in the compelling life of family and medicine; friends who took excellent care of others, but less so of themselves, and are no longer with us.

One day this month, schedule *yourself* to abide by all the generous wellness advice you give others. Carve that nitch out for your own enrichment. When life's urgencies or medicines emergencies cause you to cancel your appointment with yourself, reschedule. Then, next month find another day. Try to do what you counsel others to do and lengthen your life as a productive physician and a happy, caring member of our world, and, of course, of your own immediate and extended families. When everything in your life speaks against it . . . no time, too tired, too many activities to do with the family after office hours ran over two hours again, . . . "JUST DO IT!" . . .

Physician, heal thyself.

**Martha K. Heyburn, MD**



1995

## OCTOBER

6-17 — Allergy Abroad '95, The Ritz-Carlton Hotel, St. Louis, MO. Sponsored by Washington University School of Medicine. **Contact:** CME Office, Washington University School of Medicine, Campus Box 8063, 660 South Euclid Ave, St. Louis, MO 63110-1093; 314/362-6893; 800/325-9862.

7 — 12th Annual Ophthalmology Seminar: Management of Diabetic Retinopathy by the Comprehensive Ophthalmologist. Audubon Regional Medical Center, Louisville, KY. **Contact:** Cathy Edens, 240 Audubon Medical Plaza, Louisville, KY 40217; 502/636-2823.

13 — 4th Annual Keynote Symposium: Sleep Medicine '95, Columbus Marriott North, Columbus, Ohio. Sponsored by Riverside Methodist Hospitals in cooperation with Sleep Medicine Research Foundation, Inc. and the Ohio Sleep Medicine Institute. Category I CME credits offered. **Contact:** Sleep Medicine Research Foundation, Inc, 614/792-7632.

## NOVEMBER

5-10 — 26th Family Medicine and Primary Care Review — Session III, Hyatt Regency Hotel, Lexington, KY. **Contact:** Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

17-18 — Perinatal/Neonatal Symposium, Radisson Plaza Hotel, Lexington, KY. **Contact:** Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

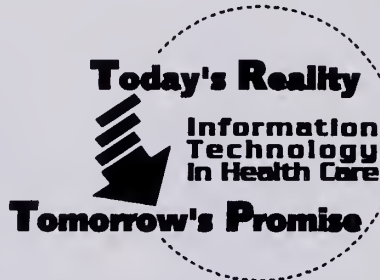
**tact:** Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 1/800/204-6333; FAX 606/323-2008.

1996

## JANUARY

28-February 3 — Practical Aspects of Diagnostic Radiology/Medical Imaging, Silvertree Hotel, Snowmass Village, CO, sponsored by Vanderbilt University Medical Center. **Contact:** Marilyn J. D'Asaro, Manager/Program Coordinator, Div of CME, Vanderbilt University School of Medicine, D-8211 Medical Center North, Nashville, TN 37232-2337; phone — 615/322-4030.

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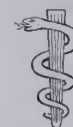
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Marla Vieillard

## The Ripple Effect

people aware of family violence and to support victims. Programs included developing forums to train health professionals to recognize and treat victims, halfway houses and shelters for women and children who are abused, funds and supplies for existing safe houses, and televised phone-a-thons to answer people's questions about the problem.

Some members worked on the health care reform because they were frustrated by the government's role in health care at the state and national level. The Alliance is the source for information for physicians' spouses on the issues facing medicine. It also is the vehicle to send a unified message to state and federal legislators. There are phone banks in 28 states that are activated at the request of the AMA to urge physicians, spouses, and families in key Congressional Districts to contact their legislators. Kentucky is in the process of updating our legislative and general phone bank list to include fax numbers. Other contact systems in 27 states enable members to respond quickly to both state and federal issues. Mini-internship programs in 24 states are giving legislators and community leaders a "walk in my shoes" look at medical practice. In Kentucky four such programs are active with more counties working on developing their programs or reactivating their mini-internship programs. All Kentucky counties are being requested to do voter registration projects, and 28

other states have also participated. We want to be sure the medical community's voice is heard at the polls.

We are all concerned about our children's, grandchildren's, or relatives children's tomorrows. Teen suicide and pregnancy, childhood immunizations, and education to give children a healthy start on life were among issues addressed in 1,100 programs last year to help children and youth. Workshops, forums, school-based education programs, brochures, videos, resource cards, and booklets were among the ways Alliance members tackled such issues as family violence, teen sexuality, substance abuse, fire safety, smoking cessation, AIDS prevention, and gun and tv violence. A large program that will be started or has been started in many schools across the USA is called "Growing Healthy." You will be hearing more about this in the future.

We care how the nation's future physicians are trained, and we actively work to raise funds through AMA-ERF, The American Medical Association Education and Research Foundation. For 5 years in a row contributions have broken the \$2 million mark, and we are near our goal again. Since 1953 the AMA Alliance with the help of many contributors has raised \$53 million for the foundation, which provides grants to medical schools and funds for assisting medical students.

The Alliance is moving with the

I know this may seem like a weird title but it is applicable to many things, not just skipping stones in ponds or spreading gossip. How about **membership**. The Alliance has many benefits to offer, and by not being a member you will lose out on not only what you can receive, but what you may be able to do for the Alliance. Many of us have undiscovered talents or talents waiting to be discovered that can be of value in this volunteer organization.

**Volunteerism** does make a difference. We appreciate each other's talents; we enhance each other's lives; we set goals and are committed to the Alliance and our spouses' **profession**.

For those of us who are members, we value what the Alliance has to offer and are concerned about the children, women, and older Americans who are victims of family violence. Last year 300 initiatives were developed in 34 states to make



times in a progressive manner. The Strategic Planning Task Force is studying and discussing organizational issues, member involvement, resource allocation, and health promotion efforts. This same progressive thinking has been present throughout the organization's history. They have been active on legislative issues, tort reform, health and safety issues, and medical family issues. The Kentucky Delegation to the Annual Convention will carefully consider all their suggestions and vote for the plan that will benefit most Alliance members at the state and national level.

The last ripple brings us to what we receive for our membership to state and national, as well as local county membership. The AMAA has investment programs, insurance programs, financing products, purchase privilege programs, home equity, hotel discounts, a bimonthly magazine, *FACETS*, whose name will be changed, leadership training, discounts on AMAA publications,

project bank, and professional skills development. On a personal level you will meet and grow to know many fascinating individuals. Some of these people will become your friends for many years to come.

As you can see, the volunteer efforts of Alliance members have a ripple effect in many areas of our lives and those in the communities in which we live. **We could achieve so much more if we had the support of all KMA members' spouses.** Your dues contribute to our projects that are being carried out even if you can't actively volunteer. The information you receive in *FACETS* and *Blue Grass News* will keep you connected to all activities at the state and national level. You may be able to use some ideas in another organization that you belong to; the ripple effect spreads forward.

For all of you who are already members, reach out to new community physician spouses and make sure they really understand how

valuable their membership is to us and that we are committed to medicine. Hopefully, your enthusiasm will extend the ripple effect and we will have a great growth in membership. If your physician spouse belongs to the KMA and/or you live in an unorganized Alliance county,

**Your membership is important** to us and you all can join us as Members At Large. We have five state MAL coordinators who will be working on building our membership across the state. Our counties will be starting their membership drives soon. **The More Members we have the More we can do,** and the **ripple of Alliance activities** will spread farther and farther. How great that will be for all of us involved in this changing medical atmosphere; and that all who know us will know we care about medicine's future and our communities' health.

**Marla Vieillard**  
KMAA President

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recommendations, those on the front line confronted with a snake bite victim will be well armed. His northern Florida home base has Eastern Diamondback, Pygmy, and Canebrake rattlesnakes, Copperheads, Cottonmouth Moccasins, Eastern and Western Massasaugas, and Coral snakes. Appropriate horse serum therapy provides effective, if not sometimes hazardous treatment.

Careful patient evaluations, sorting potential allergic hallmarks, monitoring vital signs and checkpoints along the way, and controlling the variables of treatment guarantee the guidebook's value. Readily photocopy-capable paper and

font facilitate dispensing any part to other members of the treatment team, to outlying facilities, and to individuals who get exposed to snakebite injury. A separate, but integrated "Snakebite Protocols and Consultant Director," equipped with metal holes for hanging and durable coverings, perpetuates the longevity of the guidebook, despite the insults of regular use.

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**Stephen Z. Smith, MD**  
Book Review Author

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## Hiram Polk, MD Recipient of Prestigious Honors

**H**iram C. Polk, Jr, MD, was recently in Great Britain where he was doubly honored for his efforts to reduce the death rate from surgical infection — a cause he has championed during his 24 years as chairman of surgery at the University of Louisville.

Dr Polk was inducted into the Royal College of Surgeons of Edinburgh, Scotland, the oldest surgical college in the world and among the most eminent, as an honorary fellow. This placed him among a small group of Americans, only 35, to be named honorary fellows by the Royal College. That is the highest honor bestowed by the college, which dates to the time when barbers did surgery.

And on May 26 Dr Polk became the first American to deliver the Lister Lecture at the Lister Institute's annual meeting in Aberdeen, Scotland. In so doing, he joined an elite group. Among the 13 previous lecturers were at least two Nobel Prize winners; the first lecture was given 50 years ago by Sir Alexander Fleming, who discovered penicillin.

Dr Polk's Lister Lecture was on efforts to understand and control infection after trauma.

Interestingly, Dr Polk's pursuit to defeat surgical infections began in 1969 when he was a young research assistant at this same Lister Institute of Preventive Medicine in London, which was named after Dr Joseph Lister, who pioneered antiseptic surgery in the 1860s.

The Royal College of Surgeons of Edinburgh was established in 1505, when the city's barber surgeons were incorporated as a craft guild. The college is the oldest of four institutions that certify doctors to be surgeons in Great Britain; the others are in London, Dublin, and Glasgow.

Born in Jackson, Mississippi, Dr Polk, 59, earned his medical degree from Harvard University in 1960. Eleven years later, at age 35, Dr Polk was named chairman of the surgery department at U of L. He was thought to be the youngest surgery department chairman in the nation.

Dr Polk and others at U of L have focused on surgical infection and how to prevent it for more than a decade. As early as 1969, he was publishing articles on infection, and many of the 300 journal articles he has written or co-written have been on this subject.

## \$2.2 Million Physician Beneficence Endows Chair, Professorship, and International Conference at U of L

**D**rs Lita and Sam Weakley recently gave their alma mater, the University of Louisville, \$1 million to pay the salary and support the research of a top surgical oncologist who will be recruited to U of L.

"This generous gift is especially timely in view of the fact that support for higher education is diminishing. This guarantees a high level of funding for surgical approaches to cancer at U of L in perpetuity," said Hiram C. Polk, Jr, MD, surgery department chair.

The son of a Shelby County sharecropper, Sam Weakley graduated from medical school in 1950 and later became a general surgeon. Lita Weakley postponed her education for 2 years to have the first two of the couple's four children, then returned to graduate in 1953. She became an anesthesiologist.

The couple has remained active in support of the medical school. Dr Sam Weakley served as co-chairman of the surgery department's Quest for Excellence, and helped raise the funds for the Ben A. Reid, Sr Endowed Professorship in Surgery, the department's first endowed chair. He has served as a member of the U of L Board of Trustees and currently serves on the U of L Foundation's finance committee.

The Weakley's chose the field of surgical oncology because of the relative newness of the speciality and Dr Sam Weakley's involvement on the board of directors of the James Graham Brown Cancer Center.

**A**lumnus Thomas R. Watson, MD, is donating \$1.2 million to U of L to establish a distinguished visiting professorship in rhetoric and composition and an international



conference on rhetoric and composition.

The visiting professorship and international conference will be an annual U of L event, featuring a distinguished professor from the United States or abroad who will offer advanced courses through the Department of English. Students throughout the undergraduate and graduate schools will be eligible to participate in both programs.

"The use of language and its expression is the foundation for all the various facets of a university," Dr Watson said. "The ability to transmit ideas from research to teaching to general usage is a critical function of education. I think a strong English department is vital to a major research university."

Dr Watson earned his medical degree from U of L in 1961 and later served as an assistant professor in the University's Department of OB/GYN. He is a founding director of Health



Care Partners, Celsus Inc, and Bankers Mortgage Corp, and president of Magnolia Bancorp. He is a member of the Board of Overseers at U of L.





**S**teven Hester, University of Louisville School of Medicine, was one of 50 outstanding young medical professionals recently honored by the American Medical Association at its annual National Leadership Conference. He received an AMA/Glaxo Achievement Award.

The AMA/Glaxo Achievement Awards were presented to 25 medical students and 25 residents in recognition of their exceptional leadership abilities in medicine or achievements in non-clinical community activities.

Hester has been very active in numerous local student government positions, most notably as the elected President of the medical school student body, and Health Science Center Chairman. He received the 1993-94 Student Government Association Appreciation Award. He also created and chaired the Holiday Charity Ball, a benefit for the homeless, and was one of the five selected participants in the Kentucky Interdisciplinary Community Screenings Project.

"These leaders have demonstrated they are among the country's brightest and most energetic young medical professionals," said P. John Seward, MD, Chair of the AMA's Board of Trustees. "We hope this award will encourage them to continue their quest for excellence in medicine and community service." Dr Seward is pictured above presenting the award to Hester.

## PEOPLE

**Michael D. Hagen, MD**, an associate chairman of the department of family practice at the University of Kentucky and also a tenured associate professor of Family Practice at the University's College of Medicine, has been elected president of the American Board of Family Practice (ABFP) for a 1-year term. Serving on the Board of Directors of the ABFP since 1991, Dr Hagen was elected treasurer in 1994.

**Betty B. Bibbins, MD**, Louisville, recently received two local awards: Business and Professional Women of River City's Distinguished Service Award and *The Louisville Defender's* Professional Achievement Award. She is currently vice president of the Louisville Forum.

**Jacqueline M. Sugarman, MD**, the only full-time, trained sexual abuse specialist in the Louisville and Southern Indiana area, won the first Advocate of the Year award from Children First.

Dr Sugarman, a pediatrician, treated more than 600 children from the ages of 4 months to 18 years in the last year. She has worked for 2 years for Children First, a non-profit group established in 1991 to provide services for sexually abused children and their families.

**Gerald D. Temes, MD**, Louisville, was recently named an honored recipient of the National Conference of Christians and Jews prestigious Charles Weisberg Award. The award recognizes leadership in promoting understanding and respect among all religions and cultures.

**T. Jeffrey Wieman, MD**, Louisville, has been appointed by the Royal College of Surgeons and the World Health Organization to administer surgical specialty board examinations

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## UPDATES

### UK Markey Cancer Center Receives \$1.9 Million

The UK Markey Cancer Center has received a \$1.9 million research grant from the Lucille P. Markey Charitable Trust.

The \$1.9 million grant will be used for the development of a new program in molecular genetics and gene therapy. The funds will allow UK to recruit new faculty who will bring state-of-the-art expertise to the center and will support a number of new pilot projects in this rapidly developing field.

This grant follows previous awards of nearly \$14 million from the late Lucille Parker Markey and the Markey Charitable Trust to the University of Kentucky for: The Ben F. Roach Cancer Care Facility, The Dorothy Enslow Combs Cancer Research Building, Research equipment for the M. Margrite Davis and Ralph E. Mills Magnetic Resonance Imaging and Spectroscopy Facility, Markey Scholars Awards for the UK College of Medicine, The Maxwell H. Gluck Equine Research Center.

The Lucille P. Markey Charitable Trust commenced operation in October 1983, under the provisions of the will of the late Lucille Parker Markey, who died in 1982. She directed that the trust's assets be used exclusively for "supporting and encouraging basic medical research" and that all funds be spent by 1997.

The Markey Charitable Trust has now awarded its final research program grants totaling \$15.8 million to 14 universities and research institutions. The UK Markey Cancer Center received the largest grant in this round of awards.

### KMA Legal Trust Fund Contributions

The Kentucky Medical Association would like to thank all the physicians, spouses, and other individuals who have so generously contributed to the KMA Legal Trust Fund.

At its quarterly meeting on April 12-13, the KMA Board of Trustees voted unanimously to solicit voluntary contributions of \$100 to the Fund. The Legal Trust Fund has been depleted due to KMA's fight to overturn the provider tax on physicians and KMA's lawsuit in federal court to restore Medicaid payments which have been cut by over \$50 million dollars. The suit is now in the Federal Circuit Court of Appeals, with the potential for further appeals to the US Supreme Court. Legal challenges to HB 250, the state health reform law, also appear likely.

To date, over 700 contributions have been received at the KMA Headquarters. You are encouraged to contribute. To continue our legal action in the courts, we need your support.

### Recommended Childhood Immunization Schedule

The Community and Rural Health Committee recently discussed childhood immunization schedules. The Department for Health Services has a suggested immunization schedule which it recommends to local health departments.

In addition, the Advisory Committee on Immunization Practice (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP) have formulated a recommended Childhood Immunization Schedule.

A copy of both schedules can be obtained by contacting the Communicable Disease Branch, Department for Health Services, at 502/564-3261.

in Khartoum. He will spend 2 weeks in the Republic of the Sudan next March, giving the exams.

**Robin Floyd, MD**, Louisville, KMA-RPS president, was recently awarded the AMA/Burroughs Wellcome Co Leadership Award based on proven leadership in community service.

**Larry N. Cook, MD**, U of L department of pediatrics, has been elected to serve on the executive council for the Association of Medical School Pediatric Department Chairman, Inc.

**Gordon R. Tobin, MD**, has been appointed Director of the Division of Plastic & Reconstructive Surgery at the U of L School of Medicine.

**H. Garrett Adams, MD**, and **Francisco Elbl, MD**, U of L department of pediatrics, were among 27 faculty members who recently celebrated 25 years of service to the University.

**John P. Bell, MD**, has received a special tribute from Wellspring, an organization providing housing and services for Kentucky's mentally ill. A fund-raising dinner held in his honor highlighted Dr Bell's "dedicated service to mental health and human services, in particular, his life-long contributions to improving the plight of persons with mental illness."

**Hiram C. Polk, MD**, the Ben A. Reid, Sr, Professor of Surgery at the U of L School of Medicine, has assumed two offices this year: President of the Southeastern Surgical Congress (SESC) and Chairman of the Board of Goodwill Industries of Kentucky. He has also been appointed to the United Way Campaign Cabinet as co-chair of the physician campaign effort.



## HIV/AIDS Slides Available for Physician Presentations

The Kentucky Medical Association, through the efforts of the Community and Rural Health Committee, Public Education Committee, and the Kentucky AIDS Education and Training Center, has available sets of slides on "HIV/AIDS in Kentucky" for physicians to give presentations to various groups.

The KMA has five sets available on a loan-out basis. If you are interested in borrowing a set of the slides, please contact the KMA office at 502/426-6200.

## A Workers' Compensation Reminder

As a result of an omnibus revision of Kentucky's Workers' Compensation Law (HB 928), new regulations dealing with charges for depositions and medical reports have been promulgated. The following are highlights of 803 KAR 25:160.

**APPLICABILITY** — The new regulation applies to charges by medical providers for testimony presented and medical reports furnished in the litigation of a workers' compensation claim before an administrative law judge.

**MEDICAL REPORTS** — MDs may charge not more than their usual and customary fee up to a maximum of: (a) \$200 for completion of a Form 107 or Form 108; (b) \$75 per page, with a maximum up to but not to exceed \$200, for the completion of narrative report.

**CHARGES FOR DEPOSITIONS** — "Providers . . . may charge a maximum fee not to exceed their usual and customary fee for testimony, but in no event to exceed a maximum of \$250 for the first one-half hour of testimony, and a maximum fee of \$100 for each one-quarter hour increment thereafter."

**ACCESS TO RECORDS:**  
**CERTIFICATION AND MAILING** — (a)

"A party authorized to review records of a medical provider who requests a review pursuant to KRS 342.035(7) shall submit a written request to the medical provider, describing the records to be reviewed, not less than three days in advance of the date on which the review is to take place."  
(b) Charges for copies of medical records in a workers' compensation case shall not exceed 50 cents per page plus the actual cost of postage if the records are to be mailed. If a party requests certified copies of medical records, the fee charged by the medical provider for a certification of records shall not exceed a maximum of \$10.

For questions regarding this or other workers' compensation relation matters, contact Donna Terry at Department of Workers' Claims 502/564-5550.

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1991, LA State, New Orleans

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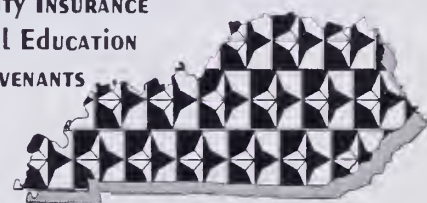


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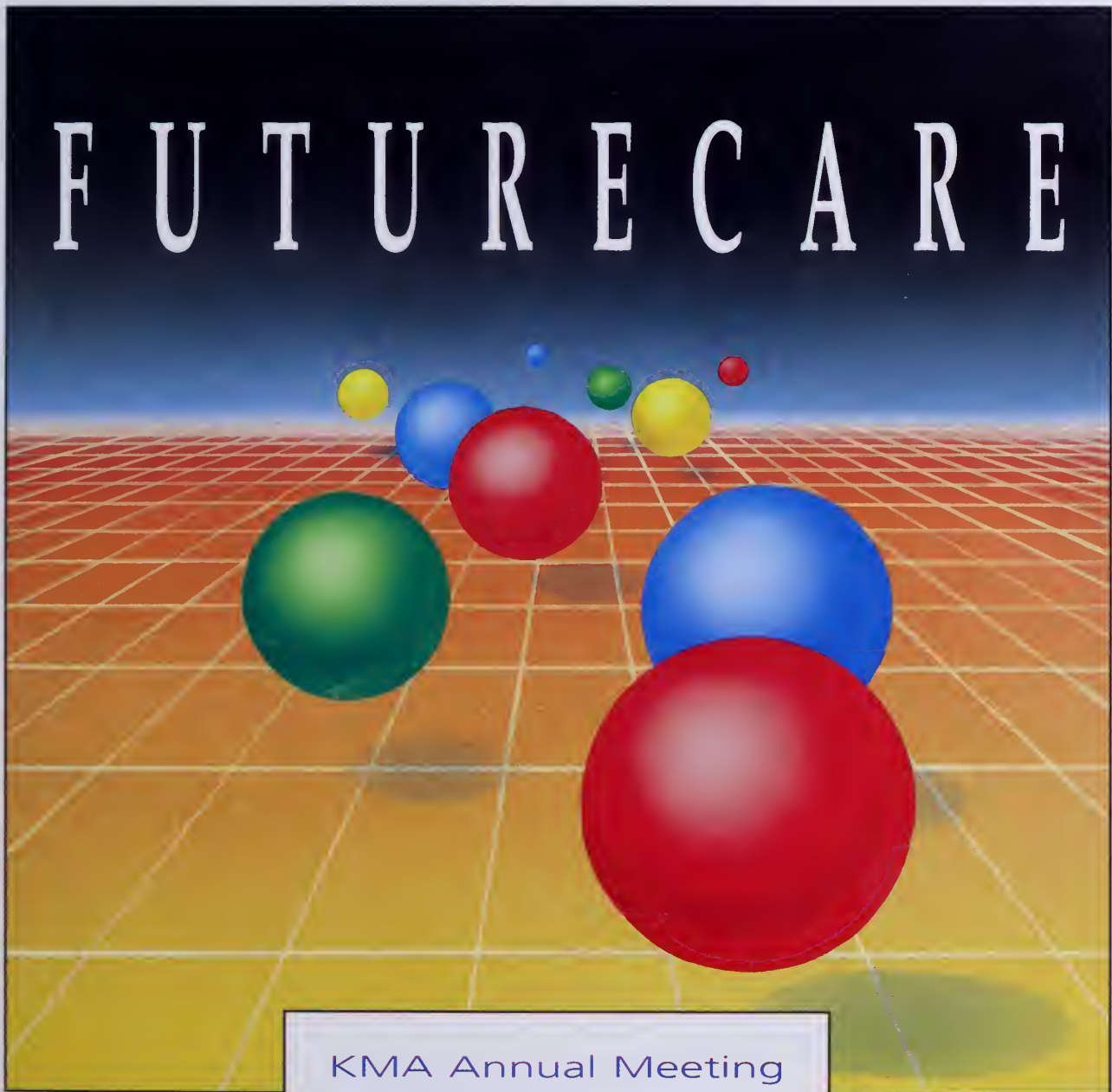
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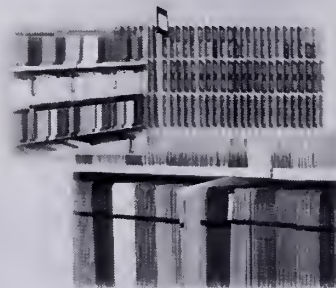
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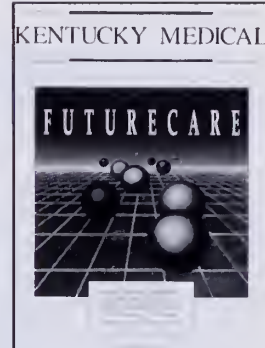
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AUGUST 1995

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**COVER: "FutureCare"** is the theme of this year's Kentucky Medical Association Annual Meeting, scheduled for September 18-21 at the Hyatt Regency Hotel in Lexington. Our cover introduces a complete preliminary program for this year's rich variety of courses showcasing front-line issues of interest to all physicians. Mark your September calendar for KMA's premier educational event!  
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# What's a Holy Grail and Why Haven't We Found It?



William H. Mitchell, MD

In the 11th, 12th, and 13th centuries, European society launched a series of three Crusades to recover the Holy Lands of the eastern Mediterranean. One essential element of the Crusades was the search for the Holy Grail, Christ's cup, used at the Last Supper. It was decided by some bright spark in the crusader "Think Tank" that recovery of this artifact would serve a positive societal end.

Unfortunately, when the quest for the Grail was undertaken, several key elements of the project were missing. At the outset, the answers to essential questions were lacking. Some of these questions are as follows:

1. Who has last seen the object?
2. What did the object look like?
3. Where had the object been seen last?
4. When was the object last seen?
5. How could the object be acquired?
6. Why was recovery of the object desirable?

In addition to these problems, no one seemed to have any idea what the cost of the search would be. There also seems to have been no clear picture as to how European society might be affected by everyone

---

*It seems to me that the recent approach to "Health Care Reform" bears similarities to the approach to the medieval Crusades. . . . Unfortunately, the same elements missing at the beginning of the medieval Crusades were missing when the search for the "Holy Grail" of Health Care Reform was begun.*

---

stopping their ongoing tasks and marching out after the Grail.

These things notwithstanding, the crusaders were off — not once, but three times! Each Crusade was prefaced by the same lack of information and each Crusade proved to be a disaster. After the 13th century, it was even postulated that

the Grail may not exist since so many well intentioned people sought it so diligently without success.

Whether the Holy Grail exists or not may be argued, but historical retrospect makes it unarguable that the plan was poorly thought out and poorly executed. The cost of the fiasco was tremendous and detrimentally affected European society for centuries.

As it turned out, the only positive elements of the Crusade came from the culture, literacy, scientific information, artifacts, and other information brought back to Europe from the very people the Europeans were fighting.

It seems to me that the recent approach to "Health Care Reform" bears similarities to the approach to the medieval Crusades.

In the last decade of the 20th century, another bright spark in a "Think Tank" suggested that "Health Care Reform" would serve a positive societal end.

Unfortunately, the same elements missing at the beginning of the medieval Crusades were missing when the search for the "Holy Grail" of Health Care Reform was begun. Some



of the unanswered questions are as follows:

1. Who has defined "Health Care Reform" and who is most involved in making changes?
  2. What are the elements of the health care system that would benefit from change?
  3. What are the key areas where modifications in the system are necessary?
  4. When and on what schedule should changes be implemented?
  5. How can we focus on constructive change and avoid destroying the finest system of medical care in the world?
  6. Why do we want to totally restructure health care delivery?
- In addition to these problems, no

one seems to be interested in allowing physicians to be involved in the decision for change. There seems to be a desire to focus on low cost medical care, but keep quality and access to care the same no matter how low the costs are set.

As a result, very powerful armies whose main weapons are political influence, legislative power, and money are charging through the country and through our state demanding that someone or some group "cough up" the Health Care Reform "Grail."

Whether *this* Holy Grail exists or not is arguable. It is, however, not arguable that specific and well thought out goals are essential for the project. We need to abandon the very term "Health Care Reform" and rather

focus on the specific elements of our health care system in which change would be of benefit.

Physicians need to be involved in the effort to focus on specificity. Physicians in Kentucky have the perception that they have been excluded from the process. In many ways that perception is justified.

It is my hope that the next step in this process will be one toward more limited and more specific modifications of the health care system rather than continued attempts at sweeping an arbitrary change. It is also my hope that physicians will be allowed to have a more effective input into the process.

**William H. Mitchell, MD**  
**KMA Vice President**

# MONITORING MEDICINE

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## NEWS FOR KENTUCKY PHYSICIANS

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### KMA PATIENT EDUCATION COMMITTEE

**A** legislative handbook to assist physicians' communications with patients, legislators and the media has been developed. The project is under the direction of the Patient Education Committee chaired by Preston P. Nunnelley, MD, of Lexington. The Handbook includes information on Medicaid, the provider tax, tort reform and other issues of importance to patients and physicians.

---

## Facts Kentucky Physicians, Medicaid, and the Provider Tax

### Medicaid

- 60% of all participating physicians received less than \$5,000 in Medicaid fees during fiscal year 1994. 69% received less than \$10,000.
- The average physician Medicaid payment per patient visit in 1994 was \$123.04. Under the new Medicaid fee schedule, that figure would be \$98.43.
- The average Medicaid payment per patient visit to family practitioners, internists and pediatricians, the largest specialty groups in Kentucky, is considerably below the overall average. Medicaid pays approximately \$25.00 for an office visit to these most frequently seen doctors.
- Physicians are paid less "per utilization" than those who transport patients to the doctor's office. (See average payment schedule - page 5)
- News stories which focus only on the few physicians who receive large total payments are misleading to the public. The percentage of doctors who have large Medicaid practices is miniscule. Only 290 (4.9%) received payments in excess of \$100,000 in FY 1994.
- 1994 statistics from the Cabinet for Human Resources show physicians received only 14% of the total Medicaid dollars spent.
- Medicaid recipients were treated or seen by physicians 2,110,559 times in 1994. The average Medicaid patient visits the doctor 4 times per year.



- Kentucky physicians continue to treat Medicaid patients without interruption. Physicians in general are very upset with the Medicaid Program, however only 128 of 5,315 have dropped out of the program (as of 3-1-95). In other words, 97.6% of the physicians who see Medicaid patients continue to do so daily.
- Approximately 75% of all Kentucky physicians eligible to participate in the Medicaid program do so.

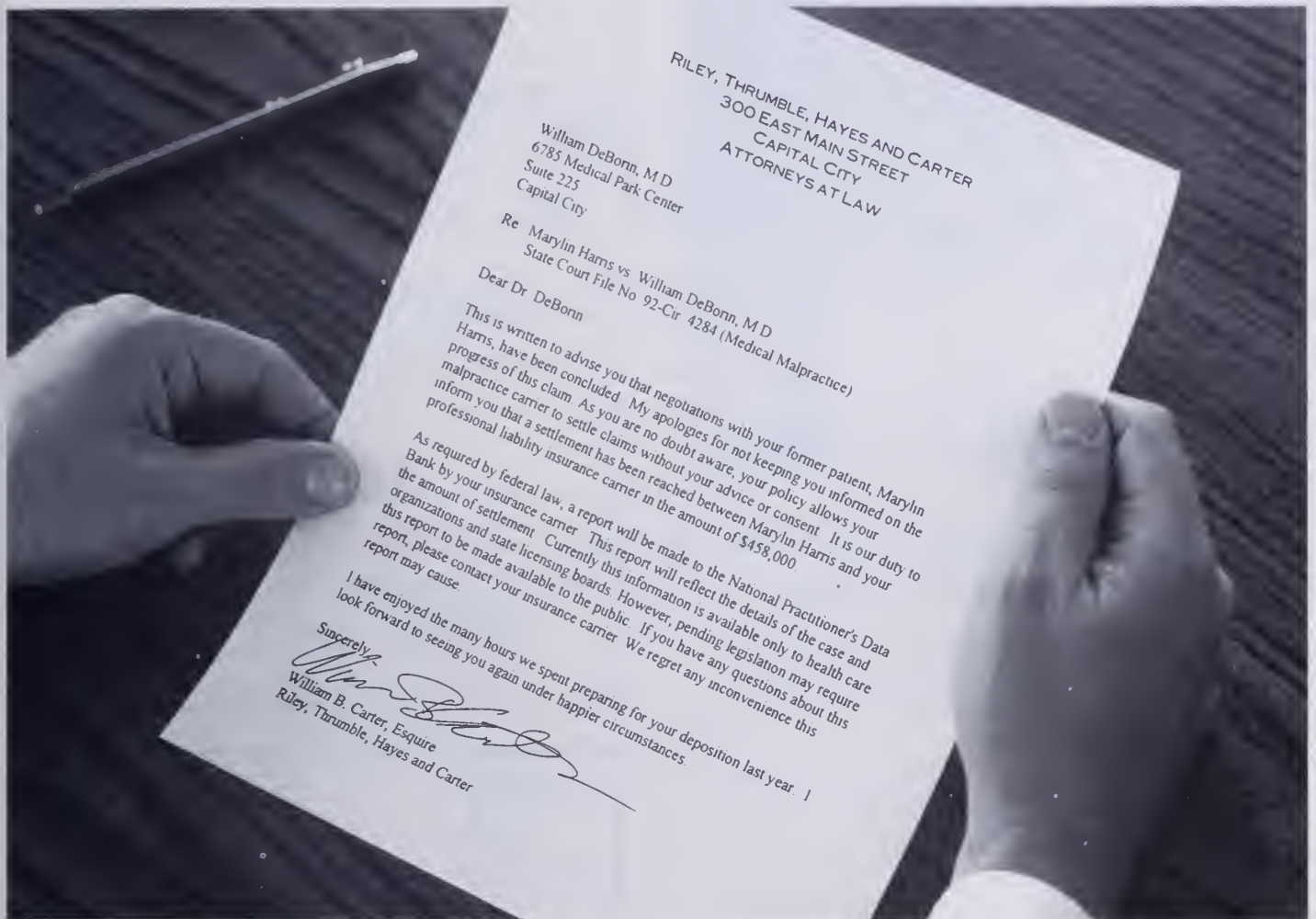
## Provider Tax

- Physicians pay 24% of the amount collected through the provider tax.
- Physicians receive only 14% of Medicaid payments.
- The actual assessment of physicians is 4%, not 2% as commonly suggested.

The average Family Practice Physician had net income of \$109,160 in 1993. However Kentucky's provider tax is based on gross income which averaged \$224,990. The average provider tax is thus \$4,485.80 or 4.1% of net income for physicians in family practice, the largest specialty group in Kentucky. (Income figures are based on a nationwide survey of physicians as published by *Medical Economics* magazine, Sept 1994.)

- Only 3 of 28 states financing Medicaid with provider taxes levy the tax against physicians.
- Kentucky is one of the only two states with a tax on physician's gross receipts. West Virginia is the other. Minnesota has a \$400.00 yearly tax.
- Physicians who do not participate in the Medicaid program are taxed.
- Most physicians who do participate in the Medicaid program pay as much, or more, in provider tax than they receive in Medicaid payments for treating patients.
- No other profession is required to pay for societal problems related to the profession. For example, attorneys are not taxed to pay the court mandated legal representation for indigents who are charged with crimes.
- With annual net income of \$109,160, physicians in family practice make less than many other professionals working in Kentucky. For example, the Executive Director of the Metropolitan Sewer District in Louisville and Jefferson County was paid \$113,027 in 1993. The President of Teamsters Local 89 had a salary of \$117,183 in 1993. Humana's Chairman & CEO drew \$2,108,122 in 1993.

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# The Impact of Major Congenital Malformations on Mortality in a Neonatal Intensive Care Unit

Dan L. Stewart, MD; Joseph H. Hersh, MD

*Neonatal mortality due to congenital malformations or genetic disorders has not decreased despite a decrease in overall neonatal deaths with recent advances in medical technology. As a consequence, an increasing percentage of neonatal deaths is attributable to congenital malformations and genetic disorders.*

*This study retrospectively reviewed neonatal deaths associated with congenital malformations over an 11-year period in the neonatal intensive care unit (NICU) at Kosair Children's Hospital, Louisville, Kentucky. Presently, congenital malformations are responsible for approximately 45% (range 32% to 61%) of deaths in the NICU with congenital heart disease, lethal genetic disorders, and pulmonary hypoplasia being the main contributors. Other major causes of neonatal death included extreme prematurity, respiratory disorders, necrotizing enterocolitis, sepsis, asphyxia, and primary pulmonary hypertension.*

*It is important that clinicians are aware that improved survival is expected for most diseases because of technological advances, but that further significant reductions in neonatal mortality will depend on genetic counseling and prevention of congenital malformations.*

In developed countries, congenital malformations account for an increasing proportion of perinatal and infant (less than 1 year of age) deaths. This relative increase has occurred because the fall in overall infant mortality from other causes has been faster than the fall in mortality due to birth defects.<sup>1</sup> Deaths attributable to major congenital anomalies now rank ahead of those due to prematurity and sudden infant death syndrome in mortality statistics for infants.

Malformations are classified as major if they

impact significantly on mortality and morbidity.<sup>2</sup>

<sup>4</sup> Minor anomalies are defined as morphological anomalies of neither medical nor cosmetic significance, and do not alter normal life expectancy.<sup>2,5</sup>

Accounting for 36% of deaths in the first year of life, major congenital anomalies are the third leading cause of childhood (1 to 14 years of age) deaths.<sup>6</sup> Since recent technological advances have improved survival in many newborn diseases, the purpose of this report is to examine the impact of major congenital anomalies on mortality in a tertiary care neonatal setting.

## Methods

Neonatal deaths due to major congenital malformations occurring between 1982-92 in the neonatal intensive care unit (NICU) at Kosair Children's Hospital, Louisville, KY, were analyzed. In addition, total admissions and deaths from other diagnostic entities other than congenital malformations also were tabulated. Deaths from congenital malformations were classified as follows: congenital heart lesions; conditions resulting in pulmonary hypoplasia including diaphragmatic hernia, Potter sequence, and lethal skeletal dysplasias; chromosome abnormalities; multiple congenital malformation syndromes, associations and unclassified multiple anomalies; and gastrointestinal defects. A fifth category labeled as other, consisted of nonimmune hydrops, urinary tract and pulmonary lesions not resulting in pulmonary hypoplasia, and inborn errors of metabolism.

Other major causes of mortality were noted to detect any changing trends in the nursery. Diseases analyzed included respiratory disorders (hyaline membrane disease and aspiration syndromes); persistent fetal circulation; necrotizing enterocolitis; sepsis; and asphyxia.

*From the Department of Pediatrics, University of Louisville School of Medicine, and Kosair Children's Hospital, Louisville, KY.*



## Impact of Major Congenital Malformations

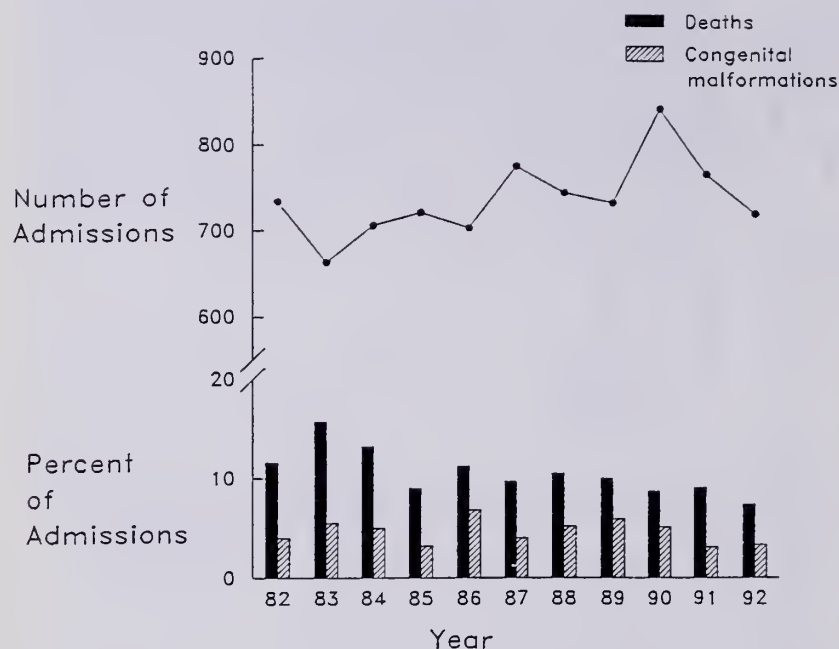


Fig 1 — Summary of admission, total deaths, and deaths with major congenital malformations by year.

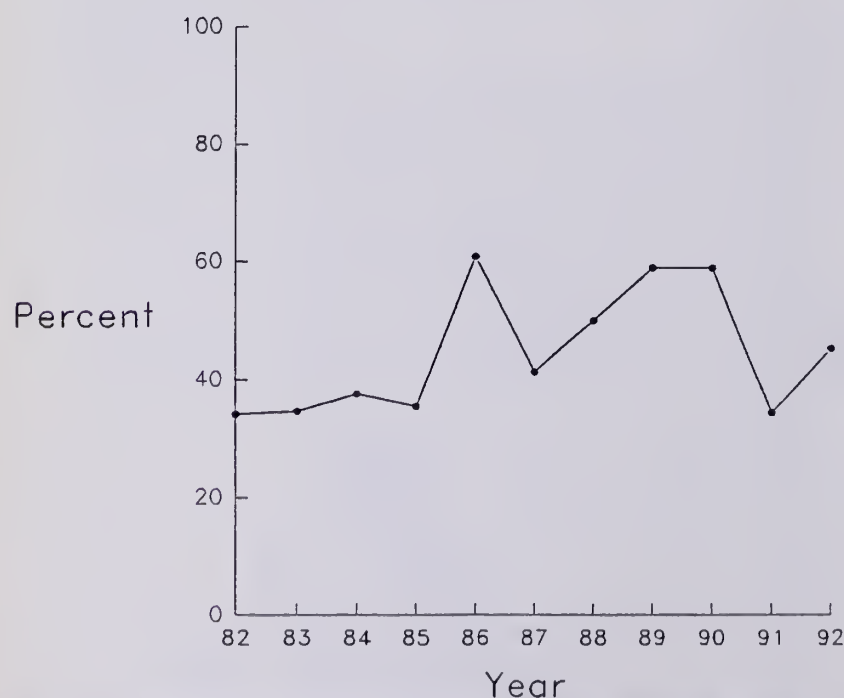


Fig 2 — Percentage of deaths attributable to major congenital anomalies over an 11 year period.

## Results

Total admissions to the NICU remained stable during the 11-year period of the study (mean 737; range 663 to 841, see Fig 1). The year, 1985, was felt to be a transitional one with the introduction of extracorporeal membrane oxygenation and neonatal heart transplantation. Despite the stability in the number of admissions, the total number of deaths decreased from 104 in 1983 to 53 in 1992 which was the lowest figure in the 11-year period. However, a concomitant fall in mortality secondary to anomalies was not seen. Deaths due to congenital anomalies now account for 35 deaths per year, approximately 50% of the total neonatal deaths in a given year (see Fig 2). Congenital heart disease, conditions resulting in pulmonary hypoplasia, and chromosome abnormalities are the major congenital malformations resulting in death (Fig 3). A wide variety of congenital heart lesions was seen. Although a significant increase in referrals for evaluation of possi-

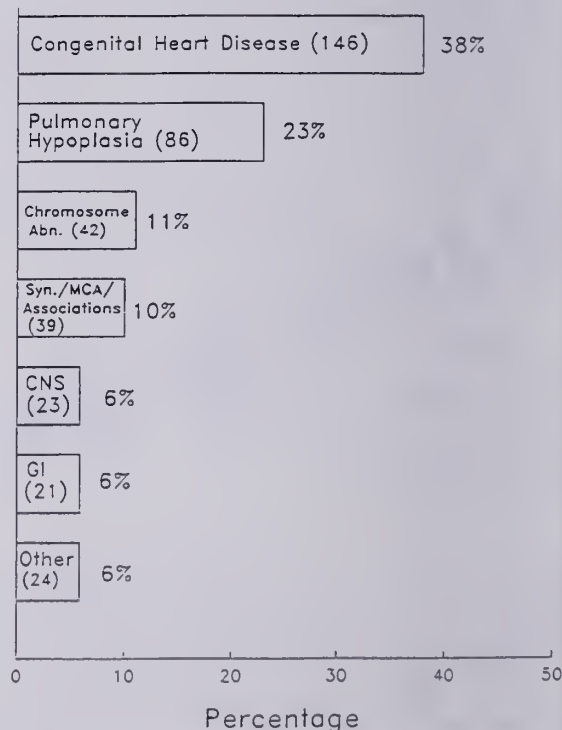


Fig 3 — Distribution of congenital anomaly deaths by major organ systems. Abbreviations: abn — abnormality, syn — syndrome, MCA — multiple congenital anomalies, CNS — central nervous system, GI — gastrointestinal.

**Table 1.** Diagnoses of deaths with congenital heart disease in the last seven years

Year	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	Total
Hypoplastic Left Heart Syndrome	1	4	3	2	7	9	7	4	6	7	4	54
Transposition of Great Arteries	3	3	3	1	2	2	3	2	1	2	3	25
Truncus Arteriosus	3	1	2	—	2	1	—	1	1	1	—	12
Pulmonary Atresia	1	2	—	1	2	1	1	2	1	1	—	12
Total Anomalous Pulmonary Venous Return	—	—	1	—	—	1	1	2	1	2	1	9
Interrupted Aortic Arch	—	2	—	1	—	1	1	—	—	—	—	5
Tetralogy of Fallot	—	—	2	—	—	—	1	—	—	2	—	5
Coarctation	1	1	2	—	—	—	—	—	—	—	—	4
Single Ventricle/Single Atrium	—	1	—	—	—	1	1	—	1	—	—	4
Double Outlet Right Ventricle	—	—	—	—	—	—	2	—	1	1	—	4
Aortic Atresia/Stenosis	—	1	1	—	1	—	—	—	—	—	—	3
Other	—	1	—	2	—	—	2	—	2	1	1	9

ble heart disease was not observed, infants with hypoplastic left heart syndrome were referred in larger numbers after institution of a heart transplant program. The distribution of the deaths from congenital heart lesions can be seen in Table 1. A rise in the number of referrals with diaphragmatic hernias also was seen during the same period with the advent of ECMO.

Other major causes of death showed a downward trend during the 11-year period. The most dramatic decline was deaths from primary pulmonary hypertension (PPHN). This number decreased from approximately 9% per year during the period 1982-84 to approximately 4% per year during the period 1986-90. This change was felt to reflect the availability of extracorporeal membrane oxygenation (ECMO) at our institution, which was used in infants who were unresponsive to conventional therapeutic modalities. At present, deaths from PPHN are rare except when secondary to other conditions. There was also a downward trend in the number of deaths from pulmonary disease from 35% in the period 1982-84 to 24% in the period 1986-90. The percentage of deaths in the latter group was influenced by the administration of artificial surfactant beginning in the years 1989 and 1990, and the introduction of jet ventilation and high frequency oscillation at our institution. During the last 2 years of the study, there continued to be a downward trend in deaths from respiratory disorders.

## Discussion

The impact that congenital malformations have on mortality in neonates is striking. As deaths from other causes continue to decrease with improving technology, the importance that congenital malformations play in neonatal mortality is becoming very apparent. Overall improvements in survival of other conditions has been the result of ECMO, high frequency oscillation, jet ventilation, and artificial surfactant therapy. However, in the case of neonates with structural abnormalities, treatment options appear to be more limited because of the nature of the defect(s), eg, inoperable heart lesion; complication secondary to the primary abnormality such as pulmonary hypoplasia; or underlying condition resulting in the malformation such as trisomy 18. Improving the outcome in some infants with a congenital malformation also is slowly beginning to become a reality, such as in the arterial switch for transposition of the great arteries, ECMO for diaphragmatic hernias, and heart transplantation for hypoplastic left heart syndrome.

Chung and Myrianthopoulos recently showed that the years of potential life lost before age 65 from congenital malformations in 1987 was 5,020 years per 10,000 population, a value that was significantly higher than that previously reported.<sup>7</sup> Considerations regarding the impact of congenital malformations must include not only



## Impact of Major Congenital Malformations

financial, but psychosocial concerns and the contribution of these malformations not only to early demise, but to chronic disease as well. These implications are realized by the infant and his family as well as society. The prognosis for malformed neonates is poor, with one in four dying in the perinatal period, one of eight being mentally retarded or having severe physical disabilities, and only one of two having a fair prognosis after treatment.<sup>8</sup> The public health burden of infants who survive with congenital malformations is a major concern to society, since resources are necessarily limited in providing optimal care for infants afflicted with potential handicapping conditions.

### Conclusion

Congenital malformations in neonates have become responsible for an increasing proportion of deaths in the NICU. With technological advances improving survival in most conditions, any significant future reduction in neonatal mortality will require more research on effective treatment modalities and emphasis on the prevention of congenital anomalies.

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## Information for Authors

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**Preparation** — Manuscripts should be typewritten in double spacing throughout, including references, tables, legends, quotations, and acknowledgments. Submit the original and one copy, retaining a copy for proofreading. Ordinarily articles should not exceed 3,000 words in length. Titles should include the words most suitable for indexing the article, should stress the main point, and should be short. A synopsis-abstract must accompany each manuscript. The synopsis should be a factual (not descriptive) summary of the work and should state the problem considered, methods, results and conclusions.

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**References** — References must be typed in double spacing on separate sheets and numbered consecutively as they are cited. They should include (in this order) the authors' names and initials, title of article (and subtitle if any), abbreviated name of journal, year, volume number, inclusive page numbers. Follow the AMA style currently in use, abbreviating the names of journals in the form given in *Index Medicus*. Authors are responsible for reference accuracy.

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# The NAAMP

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*“... the names of many minorities change from pejorative to proudly hailed and back to disgraceful so rapidly that one needs to use an electronic medium to catch that boat on time.”*

---

A minority is defined as “the smaller number; esp, in a political body, the group having less than the number of votes necessary to control —” Now our beloved society is wracked in pain over the question of the equality of persons (man). We all agonize and argue over how we can best accomplish the equalization of the dignity of our citizens and all members of humanity, and I am convinced the great majority of us feel that this goal is supremely worthy.

To specify the plights, injustices, unfair advantages, fair disadvantages, deserved and undeserved persecutions of many minorities is difficult to express in print because the names of many minorities change from pejorative to proudly hailed and back to disgraceful so rapidly that one needs to use an electronic medium to catch that boat on time. However I do want to examine the status of one such group at this point and hope that its name does not lose favor by the time of publication: women.

Whatever the position of this group be (and a majority of us have felt it to be superior all along), I am totally miffed at its unswerving insistence on claiming minority status. Compared with men, more women

are born and fewer die. Reuters says via the *Courier Journal* (June 6, 1995) that for every 170 men who die between ages 45 and 64 only 100 women die. I have the privilege of a practice including a large number of elderly patients and a large number of minority members. My judgment notes that women remain mentally competent and physically coordinated far longer than do men. In an effort to quantify this conclusion I obtained a slice of statistics from a nursing home whose population is said to be skewed toward the male. Of 140 inmates, 109 are female, 31 male. The maximum age of each is 96. The median age of females is 83, 77 of males. Returning to my anecdotal observations: the females are rational, need to be persuaded, and the males are either silent or batty.

The conclusion is obvious. Males should organize as a minority to increase their money, power, glory and influence. The organization should acquire an executive director with willful determination, perhaps Ms H. R. Clinton, and be named the National Association for the Advancement of Male Persons.

**A. Evan Overstreet, MD**  
Editor



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*Marla Vieillard*

## Fall Board and Seminar Hyatt Hotel Lexington September 18th and 19th

**A**s yuppies or baby boomers many of us are faced with the challenge of aging parents or relatives. Many of us are responsible for their care. It may even be a friend or neighbor. We all are attuned to the fact that depression can occur at any age, but it is often seen in older family members. At this Fall Board meeting we will have a seminar on "Coping and Caring for Our Aging Parents" and "Depression — There is Help." The seminar will give a generalized overview on aging that will include a segment on Alzheimer's Disease. The second component will cover signs and symptoms of depression. The speaker will offer advice, choices, and resources that are available to help us care for those immediate family members and our friends. Since medicine has made gigantic strides in the ability to offer us the best health care in the world, we will be seeing more and more

family and friends who may be suffering from Alzheimer's, other aging processes, and/or depression. This information will be current and help us make wise choices and find the best resources that will be available for their care.

Fall Board will be held on September 18th and 19th at the Hyatt, 400 West Vine Street, Lexington, Kentucky. This is not an error. Every three or four years the KMA Annual Meeting returns to Lexington. This helps those who find it difficult to reach Louisville for one reason or another. The other years it is in Louisville. Wherever the KMA Annual Meeting is held, the ALLIANCE will hold their FALL BOARD at the same hotel. So, all who have missed the last two years, we expect to see you there and catch up on your counties' activities and renew friendships.

Monday will have meetings of the Planning, Membership, and Executive Committees. We are trying a new format for the Monday lunch. We are going to have an International Buffet and our guest speaker will be from the American Medical Association Alliance. We are going to press before National has met to make assignments. Last year our Field Director was our guest. The afternoon will go by quickly with a session on new materials from the AMAA, a Legislative Update, and a speaker on

caring for fine art and antique jewelry. In the evening, we attend the KEMPAC dinner. It is a great time to network and meet KMA and KMAA members from across the state.

Tuesday morning we will have the Alliance Board Meeting. All members are welcome! Lunch will be served in the Regency Ballroom East. The Seminar speaker, Linda Kuder, will be our guest, and there will be two surprise guests from Eastern Kentucky. Our luncheon has been shortened to allow for agenda changes and to start our afternoon seminar sooner. The program is being prepared by the Sanders Brown Center on Aging. The center will be applying for credits through the Kentucky Board of Nursing. You don't have to be a nurse to garner information from this seminar. It will have something for all.

The Alliance is continuing to present information that is timely and what you have requested. The workshop seminar, Board Meeting, and luncheons are open meetings. **EVERY PHYSICIAN SPOUSE IS ENCOURAGED TO COME.** A detailed schedule is on the following page. I look forward to seeing you all at the HYATT in LEXINGTON.

**Marla Vieillard**  
KMA Alliance President



## KMA ALLIANCE FALL BOARD & WORKSHOP September 18th and 19th

### Sunday, September 17th

6:00 PM-9:00 PM Hospitality Suite open — LITE DINNER

### Monday, September 18th

7:30 AM-9:00 AM Hospitality Suite open — Continental breakfast  
Compliments of Fayette County members  
8:00 AM-11:00 AM Registration outside Patterson D  
9:00 AM-11:00 AM Committee meetings  
11:00AM-11:50 AM County Presidents and Presidents-elect meet in Hospitality Suite for county idea exchange  
12 NOON Patterson D — INTERNATIONAL BUFFET  
AMAA ALLIANCE SPEAKER  
1:40 PM Review new Alliance materials and pick up handouts  
2:15 PM Legislation Update — Dr James Crase, Senator  
3:15 PM Donald J. Merkley, Merkley Jewelers/KMA Insurance, "Estate Jewelry and Jewelry Care," exhibit samples will be modeled  
4:30 PM Nominating Committee — location Past President's choice  
6:00 PM KEMPAC RECEPTION and DINNER

### Tuesday, September 19th

7:30 AM-9:00 AM Hospitality Suite open, Compliments of Fayette County Members  
8:00 AM-11:00 AM Registration outside Regency Ballroom West  
9:00AM-12 NOON Board Meeting  
12:15 PM Luncheon-Regency Ballroom East  
speaker and guests to be announced  
1:40 PM CME WORKSHOP "Aging Parents-Advice, Choice and Resources" and "Depression, There is Help" presented by Linda Kuder from the Sanders Brown Center on Aging. Format will be suitable for all members; but credits for nurses will be available.

### SEE YOU IN SEPTEMBER AT FALL BOARD

FOR INFO CONTACT: Mrs Vida Laureano, 261 Cochran Rd, Lexington, Ky 40502-2310  
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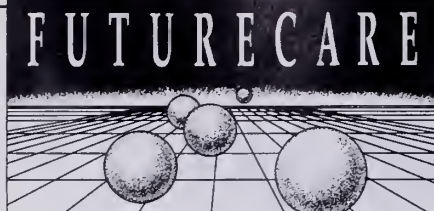
# PRELIMINARY PROGRAM

## FUTURE CARE

A 3D rendering of several spheres of varying sizes on a grid floor, receding into the distance. The spheres are dark with a lighter highlight, giving them a three-dimensional appearance. The grid floor is composed of squares that diminish in size as they recede into the distance, creating a strong sense of perspective. The background is a dark, hazy gradient.

KMA Annual Meeting  
September 18-21  
Hyatt Regency Hotel  
Lexington Center  
Lexington, Kentucky





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*\* For your convenience these pages are in a special pull-out section.*

## Official Call KMA Annual Meeting

**T**o the officers and members of the component and county medical societies of the KMA.

### **Meeting Place**

The Annual Meeting of KMA will convene on Tuesday, Wednesday, and Thursday, September 19, 20 & 21, at the Hyatt Regency Hotel and Lexington Center, Lexington. The first General Session will be called to order at 8:30 AM, Tuesday.

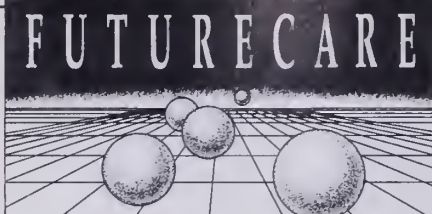
### **The House of Delegates**

The first regular meeting of the House of Delegates will convene at 9:00 AM, Monday, September 18, in the Regency Ballroom, located in the Hyatt Hotel. The second regular business meeting will begin at 7:00 PM, Wednesday, September 20, in the Patterson Ballroom.

### **Registration**

The Registration Desk, located outside the Regency Ballroom, Lobby Level of the Hyatt Hotel, will be open for Delegates at 7:30 AM, Monday, September 18, and at 6:00 PM, Wednesday, September 20. General registration will be held from 7:45 AM until 5:00 PM on Tuesday; 7:45 AM to 4:00 PM on Wednesday; and 7:45 AM to 1:00 PM on Thursday, at the General Registration Desk located in the lobby of the Lexington Center.





## KMA Officers 1994-95



**Robert R. Goodin, MD**  
KMA President

On September 20, Robert R. Goodin, MD, Louisville, will pass the mantle of leadership of the Kentucky Medical Association to Danny M. Clark, MD, Somerset.

A highly respected cardiologist, Dr Goodin has been dedicated in his nurturance of organized medicine. He is a past President of the Jefferson County Medical Society, served as a KMA Alternate Delegate to the AMA House of Delegates in 1986-90, and has served as an AMA Delegate since 1991. In 1992 Dr Goodin became a member of the AMA Continuing Medical Education Advisory Committee. He currently chairs the KMA Physician Organization Study Committee and is a member of the Scientific Program, CME, Legislative Quick Action, PLI, and Public Education Committees. He is also a member of the Joint Oversight Group on Health Care Reform.

A native of Adair County and a University of Kentucky graduate, Dr Goodin earned his medical degree from the University of Louisville School of Medicine, where he was senior class president and valedictorian.

Dr Goodin has served KMA well during his year of leadership, dedicating countless hours to improving the educational, scientific, and federation values of the Association. His performance has been exemplary as he has championed the causes of the medical community in Kentucky.



**Danny M. Clark, MD**  
President-Elect

Danny M. Clark, MD, Somerset, will be installed as President of the Kentucky Medical Association at the President's Luncheon on Wednesday, September 20.

Dr Clark, an obstetrician-gynecologist, has been diligent in his many years of dedicated service to organized medicine. He is a past President of the Pulaski County Medical Society and has been a member of the Kentucky Board of Medical Licensure since 1986. From 1974 until 1980 he served as an Alternate Trustee and from 1980 until 1986 as a Trustee for the Kentucky Medical Association. Dr Clark was elected Vice Speaker for the KMA House of Delegates in 1986 and served in that capacity until 1990 when he was elected Speaker, a position he held until 1994 when he was named President-Elect. He is a member of the Scientific Program, Legislative Quick Action, PLI, and Maternal and Neonatal Health Committees, and also serves on the Joint Oversight Group on Health Care Reform.

A native of Paris, Kentucky, Dr Clark received his undergraduate degree from Transylvania University in 1958 and his medical degree in 1962 from the University of Cincinnati.

Following completion of an internship and residency at Los Angeles County General Hospital from 1962 until 1967, Dr Clark served as a Captain in the US Air Force for 2 years, followed by establishment of his OB-GYN practice in Somerset.



Vice-President  
**William H. Mitchell, MD**  
Richmond

Dr Mitchell, a surgeon practicing in Richmond, served KMA as Delegate and as 11th District Alternate Trustee from 1981 to 1987, and as 11th District Trustee from 1988 to 1993, when he was elected Vice-President. He currently chairs the Pro Advisory Committee and is a member of the Physician Workforce and Professional Liability Insurance Committees. A 1970 graduate of the University of Kentucky College of Medicine, Dr Mitchell is a past president of the KY Chapter American College of Surgeons, the Hiram C. Polk Surgical Society, and the Madison County Medical Society.



Secretary-Treasurer  
**William P. VonderHaar, MD**  
Louisville

A family practitioner, Dr VonderHaar has served on the Interspecialty Council, Professional Education Committee, and as a Delegate for Jefferson County for several terms. He currently serves on the Legislative Quick Action, CME, and PLI Committees. He is also a member of the Joint Oversight Group on Health Care Reform. A charter fellow of the American College of Family Physicians and a member of the American Academy of Family Physicians, Dr VonderHaar was recipient of KMA's Educational Achievement Award in 1988. He is a 1956 graduate of the University of Louisville School of Medicine.



Speaker of the House  
**C. Kenneth Peters, MD**  
Louisville

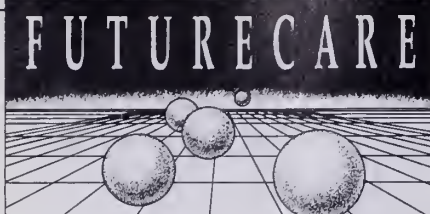
Dr Peters, a family practitioner, served KMA as Vice Speaker of the House from 1989 until 1994 when he was elected Speaker. He has also served as KEMPAC Chair, on the State Legislative Committee 17 years, and as a KMA Delegate 21 years. A past President of the Jefferson County Medical Society, Dr Peters is a member of the KMA State Legislative Activities Committee, a charter fellow of the American Academy of Family Practitioners, and a member of the Jefferson County Academy of Family Practitioners. He earned his medical degree in 1960 from the University of Louisville School of Medicine.



Vice Speaker of the House  
**John W. McClellan, Jr, MD**  
Henderson

Dr McClellan, a family practitioner, served KMA for several years in the House of Delegates and as 2nd District Alternate Trustee from 1982 until 1988, when he was elected Trustee, a position he held until his election as Vice Speaker in 1994. A 1960 graduate of the University of Louisville School of Medicine, Dr McClellan is a past President of the Henderson County Medical Society and is extensively involved in community activities.





## KMA Delegates to AMA



**Donald C. Barton, MD**  
Corbin

Dr Barton, a family practitioner, was elected AMA Delegate in 1984. He is a past Chair of the KMA Board of Trustees and past President of the Association. His extensive service includes KMA Delegate; AMA Alternate Delegate; Vice Chair, Southeastern Delegation, AMA; past President of Whitley County Medical Society; past Chair of KEMPAC Board; and 15th District KMA Trustee for several years. A 1960 graduate of the U of L School of Medicine, Dr Barton chairs the Committee on National Legislative Activities and serves on the Awards and State Legislative Activities Committees and the Physician Advisory to Health Care Access Foundation. In 1993, Dr Barton received KMA's Distinguished Service Award.



**Wally O. Montgomery, MD**  
Paducah

Dr Montgomery, a general surgeon, was elected AMA Delegate in 1988. He served KMA as Trustee for several years, as Vice-President, President-Elect, President, Alternate AMA Delegate, KEMPAC Chair, and on numerous committees. He chairs the State Legislative, Legislative Quick Action, and PLI Committees and is a member of the National Legislative and Awards Committees. A 1962 graduate of the U of L School of Medicine, Dr Montgomery is a past KY Governor and past President of the KY Chapter of the American College of Surgeons and a diplomate of the American Board of Surgery. In 1990 he was recipient of KMA's Distinguished Service Award.



**Robert R. Goodin, MD**  
Louisville

Dr Goodin, a cardiologist and current KMA President, was elected AMA Alternate Delegate in 1986 and Delegate in 1990. In 1992 Dr Goodin became a member of the AMA Continuing Medical Education Advisory Committee. He has served KMA as President-Elect and on numerous committees. He chairs the KMA Physician Organization Study Committee and is a member of the Scientific Program, CME, Legislative Quick Action, PLI, and Public Education Committees and Joint Oversight Group on Health Care Reform. Dr Goodin earned his medical degree in 1964 from the University of Louisville School of Medicine and is a fellow of the American College of Physicians and American College of Cardiology.



**Ardis D. Hoven, MD**  
Lexington

Dr Hoven, an infectious disease specialist, was elected AMA Delegate in 1993, following service as an AMA Alternate Delegate from 1989-93. Since 1992 she has been a member of the AMA Advisory Committee on Group Practice. Past service to KMA includes Delegate, Vice President, President-Elect, and President. She currently chairs the Awards Committee and Joint Oversight Group on Health Care Reform and is a member of the Legislative Quick Action and Community and Rural Health Committees and Subcommittee on Domestic Violence. A 1970 graduate of the University of Kentucky College of Medicine, Dr Hoven was the 1991 recipient of KMA's Educational Achievement Award.



**Donald J. Swikert, MD**  
Florence

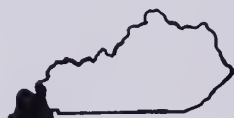
Dr Swikert, a family physician, was elected AMA Delegate in 1994. He served as AMA Alternate Delegate from 1989-94. Dr Swikert was the founding chairman of the Young Physicians Steering Committee, a KMA Alternate Trustee in 1985-88, and currently serves on the Committee to Investigate Changing Trends in Medicine and the Community and Rural Health Committee. A 1977 graduate of the University of Louisville School of Medicine, Dr Swikert is a past President of the Northern Kentucky Medical Society, past President of the Kentucky Academy of Family Physicians, diplomate of American Board of Family Practice, fellow of American Academy of Family Physicians, and an associate professor of medicine at the University of Kentucky College of Medicine.



## KMA District Trustees



**Harry W. Carloss, MD**  
First District



**Joseph E. Kutz, MD**  
Fifth District



**Donald R. Neel, MD**  
Second District



**Timothy K. Hulsey, MD**  
Sixth District



**William H. Klompus, MD**  
Third District



**Ronald E. Waldrige, MD**  
Seventh District



**Salem M. George, MD**  
Fourth District



**Mark F. Pelstring, MD**  
Eighth District

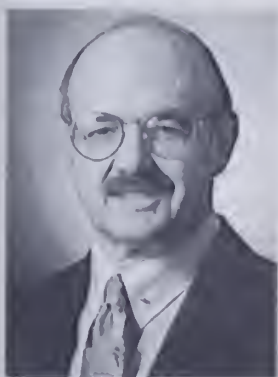




**Don R. Stephens, MD**  
Ninth District



**Kenneth R. Hauswald, MD**  
Thirteenth District



**Russell L. Travis, MD**  
Tenth District



**E. D. Roberts, MD**  
Fourteenth District



**G. Irene Minor, MD**  
Eleventh District



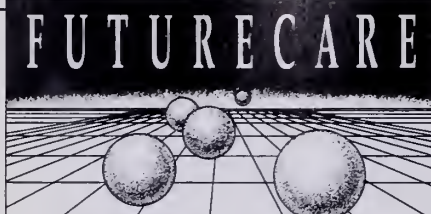
**Paul R. Smith, MD**  
Fifteenth District



**Scott B. Scutchfield, MD**  
Twelfth District







## Journal Editors

### **A. Evan Overstreet, MD, Editor** Louisville

Dr Overstreet served on the Editorial Board for more than 6 years before becoming Editor of *The Journal* in September 1977. An internist, Dr Overstreet is a 1955 graduate of the University of Louisville School of Medicine. He is a member of the American Society of Internal Medicine, the American College of Physicians, the Transylvania Medical Society, and former President of the Louisville Society of Internists.

### **Daniel W. Varga, MD** Louisville

Dr Varga, an internist, joined *The Journal* in 1990 as Scientific Editor. A 1984 graduate of the University of Louisville School of Medicine, Dr Varga has served as an Alternate Delegate and a Delegate to the KMA House of Delegates. He is current President-Elect of the Jefferson County Medical Society. Dr Varga is a diplomate of the American Board of Internal Medicine and a member of the American Association for the Advancement of Science, American College of Physicians, and the Southern Medical Association.

### **Stephen Z. Smith, MD** Louisville

Dr Smith has served as Assistant Scientific Editor for *The Journal* since 1977. He also serves as book review author. A dermatologist, Dr Smith is a 1971 graduate of Johns Hopkins University School of Medicine. He is a member of the KMA Claims and Utilization Review Committee and the American Academy of Dermatology.

### **Milton F. Miller, MD** Louisville

Dr Miller is Associate Clinical Professor of Medicine at the University of Louisville School of Medicine. An internist, Dr Miller has served as Assistant Editor of *The Journal* since 1976, has been active in the Jefferson County Medical Society, and is a former President of the medical staff at Methodist Evangelical Hospital. He is a 1954 graduate of the University of Louisville School of Medicine.

### **Martha Keeney Heyburn, MD** Louisville

Dr Heyburn joined *The Journal* in 1986 as an Assistant Editor. An ophthalmologist, Dr Heyburn is a 1980 graduate of the University of Louisville School of Medicine. She has served the Jefferson County Medical Society as an Alternate Delegate to KMA, is a member of the American Academy of Ophthalmology, and has been a member of KMA since 1981.

### **Jannice O. Aaron, MD** Louisville

Dr Aaron joined *The Journal* in 1990 as an Assistant Editor. A radiologist, Dr Aaron is a 1977 graduate of the University of Louisville School of Medicine. A Past President of the Greater Louisville Radiological Society, she is a member of several professional organizations and a diplomate of the American College of Radiology and the American Society of Neuroradiology.

### **Jaroslav P. Stulc, MD** Madisonville

Dr Stulc, a surgeon, joined *The Journal* in 1994 as an Assistant Editor. A 1973 graduate of the University of Iowa College of Medicine, Dr Stulc is affiliated with the Trover Clinic in Madisonville, Kentucky. He is a diplomate of the American Board of Surgery, a fellow of the American College of Surgeons, and an instructor for Advanced Trauma Life Support (ATLS). In addition to his duties at Trover Clinic, Dr Stulc serves as Commander, United States Naval Reserve Medical Corp-Active Duty.

## Elections

### Nominating Committee to Meet Monday, September 18

The KMA Nominating Committee will hold an open meeting at the close of the first meeting of the House of Delegates on Monday, September 18, 1995, in the Regency Ballroom of the Lexington Hyatt Regency Hotel. Any KMA member may confer with the committee during this meeting.

The report of the Nominating Committee will be posted in the general assembly hall in the Lexington Convention Center at the conclusion of the first general session, Tuesday morning, September 19.

Nominations may be made from the floor during the second meeting of the House of Delegates on Wednesday evening, September 20. The House will vote on the nominees at this meeting.

Members of the Nominating Committee are: James R. Bean, MD, Lexington, Chair; James D. Crase, MD, Somerset; Joe T. Davis, MD, Bowling Green; Jayne L. Hollander, MD, Louisville; and Michelle M. Murray, MD, Alexandria.

Nominations should be sent before the Annual Meeting to the KMA Headquarters Office to the attention of the Nominating Committee.

### House to Elect New Officers During Annual Meeting

KMA officers for the 1995-96 Association year will be elected by the House of Delegates at the close of its final meeting, Wednesday evening, September 20. Officers to be elected from the state-at-large are:

Office	Term
President-Elect	1 Year
Vice President	1 Year
Speaker, House of Delegates	3 Years
*C. Kenneth Peters, MD Jeffersontown	
Vice Speaker, House of Delegates	3 Years
*John W. McClellan, MD Henderson	
Delegates to AMA	2 Years
*Donald C. Barton, MD Corbin	
*Ardis D. Hoven, MD Lexington	
Alternate Delegates to the AMA	2 Years
*J. Gregory Cooper, MD Cynthiana	
*G. Irene Minor, MD Berea	
*Incumbent	

### Election of Trustees and Alternate Trustees

The House of Delegates will elect five District Trustees and five Alternate Trustees at its second regular meeting, Wednesday, September 20, 1995. Nominations will be made by the Delegates from the electing Districts at a meeting following the first meeting of the House, on Monday, September 18.

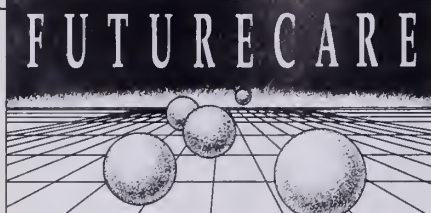
The Nominating Committee will report at the close of the first scientific session on Tuesday, September 19. Further nominations may be made from the floor at the final meeting of the House on Wednesday evening, September 20. All nominations are considered and acted upon by the Delegates at this final meeting.

Districts electing Trustees for 3-year terms are: 1st District (incumbent, Harry W. Carlross, MD, Paducah); 3rd District (incumbent, William H. Klompus, MD, Madisonville); 4th District (incumbent, Salem M. George, MD, Lebanon); 12th District (incumbent, Scott B. Scutchfield, MD, Danville); and 14th District (incumbent, E.D. Roberts, MD, Pikeville). Trustees in all five Districts are eligible for reelection to a second 3-year term.

Districts electing Alternate Trustees are the same as those electing Trustees. Incumbents are: 1st District, Dan M. Miller, MD, Murray; 3rd District, Charles R. Dodds, MD, Earlington; 4th District, Jeffrey B. Richardson, MD, Elizabethtown; and 12th District, Donald E. Brown, MD, Somerset.

Alternate Trustees in the 4th and 12th Districts are eligible for reelection; while those in the 1st and 3rd Districts have both served two, consecutive terms and are not eligible for reelection. In addition, there is a vacancy in the 14th District, and an Alternate Trustee needs to be elected for a full 3-year term.





## Reference Committee Activity

Speakers C. Kenneth Peters, MD, Louisville, and John W. McClellan, Jr, MD, Henderson, will assign all officers' and committees' reports and resolutions to one of five reference committees at the first meeting of the KMA House of Delegates at 9:00 AM, Monday, September 18. A brief session for reference committee chairs will be held at 12:00 NOON, Monday, in Patterson E, located on the lower level of the Hyatt Hotel. Any KMA member wishing to testify on any resolution or report is urged to be present for the reference committee meetings which will be held at 1:00 PM, Monday, September 18, in the lower level meeting

rooms in the Hyatt Hotel. These open sessions will last at least one hour in order for all who wish to speak to be heard. Following the open hearings, the committees will go into executive session to study the reports, review the testimony, and write their reports to the House.

The committees' recommendations will be presented at the final meeting of the House, Wednesday evening, September 20, in the Patterson Ballroom, Hyatt Hotel.

Appointments for reference committees, the Credentials Committee, and Tellers are now being finalized by the Speakers. If your society has not yet

submitted the name of your delegate(s) to the Headquarters Office, you should do so immediately, as only those names recorded in the office can be considered for appointment to one of the reference committees and be listed as official county society representatives.

A complete listing of members who will be serving on the five reference committees and the location of the reference committee meetings will be published in the September issue of the *KMA Journal*. Anyone desiring names of reference committee members before the September issue is published should contact the Headquarters Office.

## MAKE YOUR RESERVATIONS NOW!

**It is important that you begin to make your room reservations as soon as possible for the KMA Annual Meeting, September 18-21. The Hyatt Regency Lexington will be the Headquarters Hotel (Phone 606/253-1234). In making your reservations, remember the first House of Delegates meeting will be Monday, September 18. Be sure and identify yourself as a KMA meeting attendee to receive the special convention rate --- Single - \$91/Double - \$101.**

# KMA Delegates

## FIRST DISTRICT

### Ballard

Martha C. Robinson, MD, Barlow

### Calloway

Robert C. Hughes, MD, Murray

Rob T. Williams, MD, Murray

### Carlisle

### Fulton

Edward B. McWhirt, MD, Fulton

### Graves

Charles E. Bea, MD, Mayfield

Patricia S. Elliott, MD, Mayfield

### Hickman

Bruce C. Smith, MD, Clinton

### Livingston

Stephen Burkhardt, MD, Salem

### McCracken

W. Winston Barnard, MD, Paducah

James R. Gould, MD, Paducah

John E. Grubbs, MD, Paducah

Peter E. Locken, MD, Paducah

John D. Noonan, MD, Paducah

Allen L. Tinsley, MD, Paducah

Ronald L. Wilson, MD, Paducah

### Marshall

## SECOND DISTRICT

### Daviess

Gerald G. Edds, MD, Owensboro

Christopher J. Havelda, MD, Owensboro

John D. Loucks, MD, Owensboro

William Carl Madauss, MD, Owensboro

Wathen Medley, Jr, MD, Owensboro

Robert H. Schell, MD, Owensboro

William L. Tyler, III, MD, Owensboro

### Hancock

### Henderson

John S. Cave, MD, Henderson

Marcia L. Cave, MD, Henderson

Marshall Howell, III, MD, Henderson

### McLean

### Ohio

Eric A. Norsworthy, MD, Hartford

### Union

Wallis N. Bell, MD, Morganfield

### Webster

## THIRD DISTRICT

### Caldwell

### Christian

### Crittenden

### Hopkins

Iyad A. Al-Jabi, MD, Madisonville

Wallace R. Alexander, MD, Madisonville

James M. Bowles, MD, Madisonville

Uday V. Dave, MD, Madisonville

### Lyon

### Muhlenberg

James S. Brashear, MD, Central City

### Todd

### Trigg

## FOURTH DISTRICT

### Breckinridge

### Bullitt

### Grayson

Arthur J. McLaughlin, II, MD, Leitchfield

## Green

### Hardin

Arvil G. Catlett, MD, Hodgenville

William C. Nash, MD, Elizabethtown

Mahendra Patel, MD, Elizabethtown

Jeffrey B. Richardson, MD, Elizabethtown

David J. Zoeller, MD, Elizabethtown

### Hart

James W. Middleton, Jr, MD, Munfordville

### Larue

### Marion

Richard L. Litt, MD, Lebanon

### Meade

Raymond L. Mathis, DO, Brandenburg

### Nelson

Lloyd A. Manchikes, MD, Bardstown

### Taylor

Eugene H. Shively, MD, Campbellsville

### Washington

Brian F. Wells, MD, Springfield

## FIFTH DISTRICT

### Jefferson

Jannice O. Aaron, MD, Louisville

David T. Allen, MD, Louisville

Stephanie S. Altobellis, MD, Louisville

Kenneth C. Anderson, MD, Louisville

Joseph C. Banis, Jr, MD, Louisville

Arnold M. Belker, MD, Louisville

S. J. Bertolone, Jr, MD, Louisville

Charles J. Bisig, Jr, MD, Louisville

David H. Bizot, MD, Louisville

Harold W. Blevins, MD, Louisville

Susan G. Bornstein, MD, Louisville

C. Matthew Brown, MD, Louisville

Gregory L. Brown, MD, Louisville

David E. Bybee, MD, Louisville

Peter C. Campbell, MD, Louisville

Donn R. Chatham, MD, Louisville

Gregory J. Ciliberti, MD, Louisville

Stuart P. Cohen, MD, Louisville

Peter M. Conway, MD, Louisville

Deborah L. Copeland, MD, Louisville

Warren Cox, IV, MD, Louisville

Frederick Cressman, Jr, MD, Louisville

Rudy J. Ellis, Jr, MD, Louisville

Samuel G. Eubanks, Jr, MD, Louisville

John M. Farmer, MD, Louisville

Marjorie R. Fitzgerald, MD, Louisville

Gary L. Fuchs, MD, Louisville

Katherine P. Garrison, MD, Louisville

Linda H. Gleis, MD, Louisville

Leonard A. Goddy, MD, Louisville

Lawrence G. Goldberg, MD, Louisville

Scott A. Haas, MD, Louisville

Harold D. Haller, MD, Louisville

Kathleen C. Harter, MD, Louisville

B. Thomas Harter, Jr, MD, Louisville

John G. Hubbard, MD, Louisville

Walter I. Hume, Jr, MD, Louisville

Barbara Sue Isaacs, MD, Louisville

Sheri A. Kalbfleisch, MD, Louisville

John M. Karibo, MD, Louisville

Virginia T. Keeney, MD, Louisville

Donald R. Kmetz, MD, Louisville

A. O'tayo Lalude, MD, Louisville

Gerald M. Larson, MD, Louisville

Michael T. Macfarlane, MD, Louisville

Russell T. May, MD, Louisville

Mario Maya, MD, Louisville

Martha T. McCoy, MD, Louisville

Gordon T. McMurry, MD, Louisville

Frank B. Miller, MD, Louisville

Cathleen J. Morris, MD, Louisville

Richard R. Morris, MD, Louisville

Richard R. Nave, MD, Louisville

Hugh R. Peterson, Jr, MD, Louisville

Hiram C. Polk, Jr, MD, Louisville

Steve J. Raible, MD, Louisville

James E. Redmon, MD, Louisville

K. Thomas Reichard, MD, Louisville

Joseph S. Sanfilippo, MD, Louisville

George Randolph Schrodt, MD, Louisville

George R. Schrodt, Jr, MD, Louisville

Edward L. Scofield, MD, Louisville

Judah L. Skolnick, MD, Louisville

William C. Templeton, III, MD, Louisville

Regulo J. Tobias, MD, Louisville

Stuart Urbach, MD, Louisville

Daniel W. Varga, MD, Louisville

Henry J. Walter, MD, Louisville

Norton G. Waterman, MD, Louisville

David R. Watkins, MD, Louisville

Samuel D. Weakley, MD, Louisville

Barbara Weakley-Jones, MD, Louisville

Russell A. Williams, MD, Louisville

Kenneth N. Zegart, MD, Louisville

## SIXTH DISTRICT

### Adair

Richard Lenaghan, MD, Columbia

### Allen

John M. Hall, MD, Scottsville

### Barren

Warren J. Eisenstein, MD, Glasgow

Melissa Walton-Shirley, MD, Glasgow

### Butler

Richard T. Wan, MD, Morgantown

### Cumberland

Joseph D. Skipworth, MD, Burkesville

### Edmonson

Omkar N. Bhatt, MD, Brownsville

### Logan

### Metcalfe

Lawrence P. Emberton, MD, Edmonton

### Monroe

James E. Carter, MD, Tompkinsville

### Simpson

Michael Pulliam, MD, Franklin

### Warren

James F. Beattie, Jr, MD, Bowling Green

John T. Burch, MD, Bowling Green

Robert J. Emslie, MD, Bowling Green

Timothy K. Hulse, MD, Bowling Green

## SEVENTH DISTRICT

### Anderson

Kenneth E. Hines, MD, Lawrenceburg

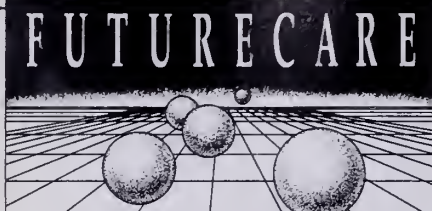
### Carroll

Frank Frost Palmer, MD, Carrollton

### Franklin

Willis P. McKee, Jr, MD, Frankfort





John M. Patterson, MD, Frankfort  
William F. Threlkeld, MD, Frankfort

#### **Gallatin**

Benjamin Kutnicki, MD, Warsaw

#### **Grant**

#### **Henry**

James R. Smith, MD, Shelbyville

#### **Oldham**

Harold F. Funke, MD, Crestwood

#### **Owen**

#### **Shelby**

Ronald E. Waldrige, MD, Shelbyville

#### **Spencer**

Thomas C. Crain, MD, Taylorsville

#### **Trimble**

### **EIGHTH DISTRICT**

#### **Boone**

Robert L. Baker, Jr, MD, Crescent Springs

Michael L. Robinson, MD, Covington

#### **Campbell**

James L. Evans, III, MD, Fort Thomas

Steven L. Willett, MD, Fort Thomas

Steven M. Woodruff, MD, Florence

#### **Kenton**

Gordon W. Air, MD, Crestview Hills

Albert D. Baldrige, Jr, MD, Covington

Thomas E. Bunnell, MD, Erlanger

Mark A. Cepela, MD, Edgewood

Joseph C. Martin, MD, Erlanger

Ross McHenry, MD, Covington

George E. Miller, MD, Crescent Springs

Theodore H. Miller, MD, Edgewood

Richard E. Park, MD, Covington

Marguerite S. Schabell, MD, Florence

B. Robert Schwartz, MD, Edgewood

### **NINTH DISTRICT**

#### **Bath**

#### **Bourbon**

Emmett Lee Tate, MD, Paris

#### **Bracken**

#### **Fleming**

Glenn R. Womack, MD, Flemingsburg

#### **Harrison**

Donald R. Stephens, MD, Cynthiana

#### **Mason**

Leroy Shouse, MD, Maysville

#### **Nicholas**

#### **Pendleton**

Robert L. McKenney, MD, Falmouth

#### **Robertsan**

#### **Scott**

### **TENTH DISTRICT**

#### **Fayette**

James W. Baker, MD, Lexington

James R. Bean, MD, Lexington

David J. Bensema, MD, Lexington

John V. Borders, MD, Lexington

Terry David Clark, MD, Lexington

John W. Collins, MD, Lexington

W. Lisle Dalton, MD, Lexington

Elvis S. Donaldson, Jr, MD, Lexington

Richard D. Floyd, IV, MD, Lexington

Carol L. Fowler, MD, Lexington

John M. Fox, MD, Lexington

Bill H. Harris, MD, Lexington

Raleigh O. Jones, MD, Lexington

Magdalene B. Karon, MD, Lexington

Dennis B. Kelly, MD, Lexington

Daniel E. Kenady, Sr, MD, Lexington

John M. Moore, MD, Lexington

William N. Offutt, IV, MD, Lexington

Charles L. Papp, MD, Lexington

Barbara A. Phillips, MD, Lexington

John W. Poundstone, MD, Lexington

Glenn R. Shearer, MD, Lexington

Thomas K. Slabaugh, MD, Lexington

David B. Stevens, MD, Lexington

John D. Stewart, MD, Lexington

John Robert White, MD, Lexington

Emery A. Wilson, MD, Lexington

T. Allen Woodward, MD, Lexington

#### **Jessamine**

#### **Woodford**

C. Dale Goodin, MD, Versailles

### **ELEVENTH DISTRICT**

#### **Clark**

#### **Estill**

John A. Patterson, MD, Irvine

#### **Jackson**

#### **Lee**

James B. Noble, MD, Beattyville

#### **Madison**

#### **Menifee**

#### **Montgomery**

Richard A. Hall, MD, Mount Sterling

#### **Owsley**

#### **Powell**

Charles G. Noss, MD, Stanton

#### **Wolfe**

Wallace L. Past, Jr, MD, Campton

### **TWELFTH DISTRICT**

#### **Boyle**

David C. Liebschutz, MD, Danville

Arthur K. Rivard, MD, Danville

Scott B. Scutchfield, MD, Danville

#### **Casey**

Lewis E. Wesley, MD, Liberty

#### **Clinton**

Michael Lee Cummings, MD, Albany

#### **Garrard**

Paul J. Sides, MD, Lancaster

#### **Lincoln**

C. Glen Click, MD, Stanford

#### **McCreary**

#### **Mercer**

George W. Noe, MD, Harrodsburg

#### **Pulaski**

Khalid Iqbal, MD, Somerset

Billy Joe Parson, MD, Somerset

Joseph G. Weigel, MD, Somerset

#### **Rockcastle**

William D. Dooley, MD, Mount Vernon

#### **Russell**

H. Michael Oghia, MD, Russell Springs

#### **Wayne**

Edward Joseph, MD, Monticello

### **THIRTEENTH DISTRICT**

#### **Boyd**

Paul W. Craig, II, MD, Ashland

Maurice J. Oakley, MD, Ashland

John R. Potter, MD, Ashland

Susan Hess Prasher, MD, Ashland

Charles T. Watson, MD, Ashland

#### **Carter**

Dante R. Oreta, MD, Grayson

#### **Elliott**

#### **Greenup**

John O. Jones, MD, Flatwoods

Lourente B. Tigas, MD, Russell

#### **Lawrence**

Michael Pravetz, MD, Louisa

#### **Lewis**

#### **Morgan**

George R. Bellamy, MD, West Liberty

#### **Rowan**

Alan T. Mong, MD, Morehead

### **FOURTEENTH DISTRICT**

#### **Breathitt**

#### **Floyd**

Nicholas R. Jurich, MD, Prestonsburg

Raghu R. Sundaram, MD, Martin

#### **Johnson**

Franken K. Belhasen, MD, Paintsville

#### **Knott**

#### **Letcher**

Van S. Breeding, MD, Whitesburg

#### **Magoffin**

Charles E. Hardin, Jr, MD, Salyersville

#### **Martin**

Lon E. Lafferty, MD, Inez

#### **Perry**

Gilroy Lane Daley, MD, Hazard

#### **Pike**

Baretta R. Casey, MD, Pikeville

Lela C. Maynard, MD, Pikeville

Charles G. Nichols, MD, Pikeville

### **FIFTEENTH DISTRICT**

#### **Bell**

Meredith J. Evans, MD, Middlesboro

Charles C. Moore, Jr, MD, Middlesboro

#### **Clay**

William E. Becknell, MD, Manchester

#### **Harlan**

F. Andrew Morfesis, MD, Harlan

Milo H. Schosser, MD, Benham

#### **Knox**

Rogelio A. Acosta, MD, Barbourville

#### **Laurel**

David W. Douglas, MD, London

#### **Leslie**

Roy Varghese, MD, Hyden

#### **Whitley**

### **KMA Hospital Medical Staff Section**

William D. Pratt, MD, London

### **KMA Resident Physicians Section**

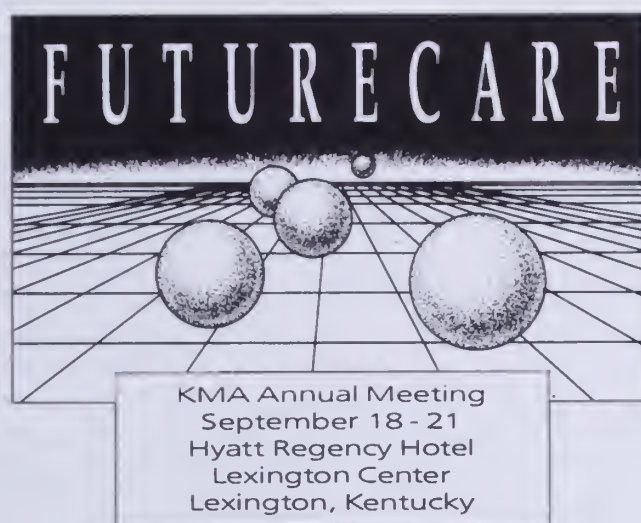
Judy M. Linger, MD, Georgetown

### **KMA Student Section**

John Bruner, Lexington

Matt McDonald, Louisville

## Annual Meeting Special Features



### 1995 Annual Meeting Honors Past President John James Moren, MD AMA President-Elect Daniel H. Johnson, Jr, MD, to Address KMA House of Delegates

**T**he 1995 Annual Meeting of the Kentucky Medical Association will be officially titled "The John James Moren Meeting" in remembrance of the 1915 President of the Association. The tradition of honoring a past president of KMA and other distinguished physicians originated with the 1935 Annual Meeting. Eugene H. Conner, MD, Louisville, KMA Historian, has written a biography on Dr Moren that begins on page 357.

**Scientific Sessions** are scheduled for September 19 and 20 at the Lexington Center in Lexington. The theme for the 1995 scientific session is "FutureCare." Both the presentations and discussion periods will contribute to the continuing medical education of Kentucky's physicians.

**Twenty-two Specialty Groups** will

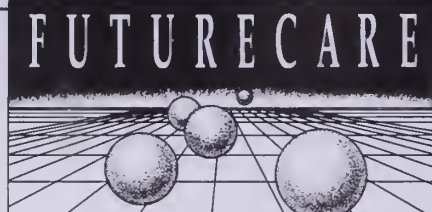
hold meetings on September 19, 20, and 21 beginning at 1:30 PM on Tuesday, 2:15 PM on Wednesday, and 9:00 AM on Thursday. Individual programs of specialty societies and meeting locations are listed in this issue. All general sessions will be held in the mornings. Specialty groups will meet all three days with no general sessions scheduled during these specialty group meetings. All KMA members are invited to attend any specialty meetings.

**Scientific and Technical Exhibits** will display new medical products, services, and techniques in the Exhibit Hall, located in the Lexington Center, during the 1995 Annual Meeting. Members and guests are urged to take the opportunity to view products of interest at the 30-minute intermissions scheduled during each general and specialty session.

**The KMA House of Delegates** will meet twice during the Annual Meeting. The first meeting of the House will be held at 9:00 AM, Monday, September 18, in the Regency Ballroom located in the Hyatt Hotel. Daniel H. Johnson, Jr, MD, President-Elect of the American Medical Association, will be the featured speaker at this meeting. The final meeting will be held Wednesday, September 20, at 7:00 PM, in the Patterson Ballroom. Officers for the 1995-96 Associational year will be elected at the second meeting.

**The President's Installation & Awards Luncheon** will be held on Wednesday, September 20, in the Patterson Ballroom located in the Hyatt Hotel. The luncheon will include the presentation of KMA awards and the installation of the 1995-96 President, Danny M. Clark, MD, Somerset.





# Capsule Schedule of 1995 Annual Meeting

LC = Lexington Center  
HH = Hyatt Regency Hotel

## Sunday, September 17

- 9:00 AM KMA Executive Committee Meeting  
12:30 PM KMA Board of Trustees Meeting & Lunch

Regency Ballroom East-HH  
Regency Ballroom West-HH

## Monday, September 18

- 7:30 AM Registration for House of Delegates  
7:30 AM Continental Breakfast for House of Delegates  
hosted by FCMS  
9:00 AM First Meeting, KMA House of Delegates  
9:00 AM Alliance Committee Meetings/Lunch  
10:00 AM Trustee Districts Nominating Committees/  
KMA Nominating Committee  
11:45 AM Rural Caucus/Luncheon  
12:00 NOON Reference Committee Chair Luncheon  
1:00 PM Reference Committee Meetings  
6:00 PM KEMPAC Reception  
7:00 PM KEMPAC Dinner

Outside Regency Ballroom-HH  
Regency Ballroom East-HH

Regency Ballroom-HH  
Patterson Ballroom D-HH  
Regency Ballroom-HH

Washington Room-HH  
Patterson Ballroom E-HH  
Various Meeting Rooms-HH  
Atlanta Room-HH  
Regency Ballroom-HH

## Tuesday, September 19

- 7:00 AM KEMPAC Board Breakfast Meeting  
7:45 AM Registration  
8:00-9:00 AM Reference Committee Report Signing  
8:15-9:00 AM Free Coffee & Danish  
8:30 AM Opening Ceremonies, First Scientific Session  
9:00 AM Alliance Fall Board Meeting  
12:00 NOON Young Physicians Luncheon  
12:00 NOON Executive Committee & Reference Committee  
Chair Luncheon Meeting  
12:30 PM Alliance Luncheon  
1:00 PM MSS/RPS Annual Meeting  
1:30 PM Specialty Group Sessions . . . 8 Specialty Groups  
will meet simultaneously at this time.  
2:00 PM Alliance Workshop

Patterson Ballroom D-HH  
Registration Area-LC  
Mary Todd Lincoln Room-HH  
Exhibit Hall-LC  
General Sessions Area-LC  
Regency Ballroom West-HH  
Lexington Room-HH  
Washington Room-HH

Regency Ballroom East-HH  
Ballroom 3-LC  
Various Meeting Rooms-LC  
(Programs begin on page 361)  
Regency Ballroom West-HH

## Wednesday, September 20

- 7:45 AM Registration  
8:15-9:00 AM Free Coffee & Danish  
8:30 AM Second Scientific Session  
11:50 AM President's Installation/Awards Luncheon  
2:15 PM Specialty Group Sessions . . . 8 Specialty Groups  
will meet simultaneously at this time.  
3:00 PM KMA Board of Trustees Meeting  
5:00 PM Rural Caucus Meeting/Dinner  
7:00 PM Second Meeting, KMA House of Delegates

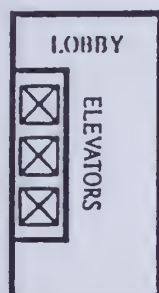
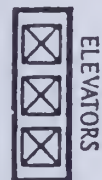
Registration Area-LC  
Exhibit Hall-LC  
General Sessions Area-LC  
Patterson Ballroom-HH  
Various Meeting Rooms-LC  
(Programs begin on page 365)  
Atlanta Room-HH  
Regency Ballroom Center-HH  
Patterson Ballroom-HH

## Thursday, September 21

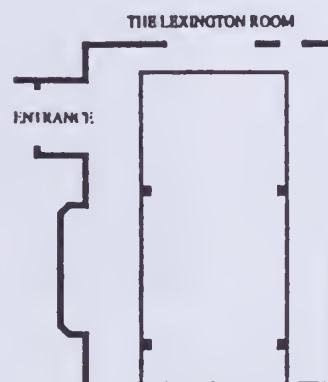
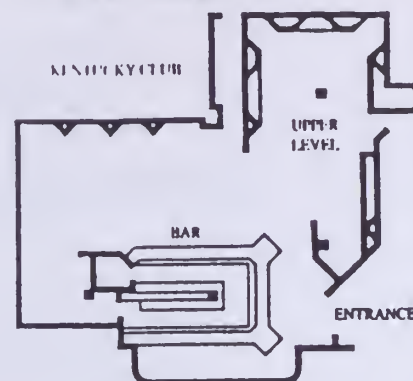
- 7:30 AM KMA Board of Trustees Breakfast Meeting  
7:45 AM Registration  
8:15-9:00 AM Free Coffee & Danish  
9:00 AM Specialty Group Sessions . . . 6 Specialty Groups  
will meet simultaneously at this time.  
9:30 AM HIV Update for Physicians

Atlanta Room-HH  
Registration Area-LC  
Exhibit Hall-LC  
Various Meeting Rooms-LC  
(Programs begin on page 366)  
General Sessions Area-LC

*A 30-minute intermission has been scheduled during each Scientific Session  
and Specialty Group Session for visiting Exhibits.*

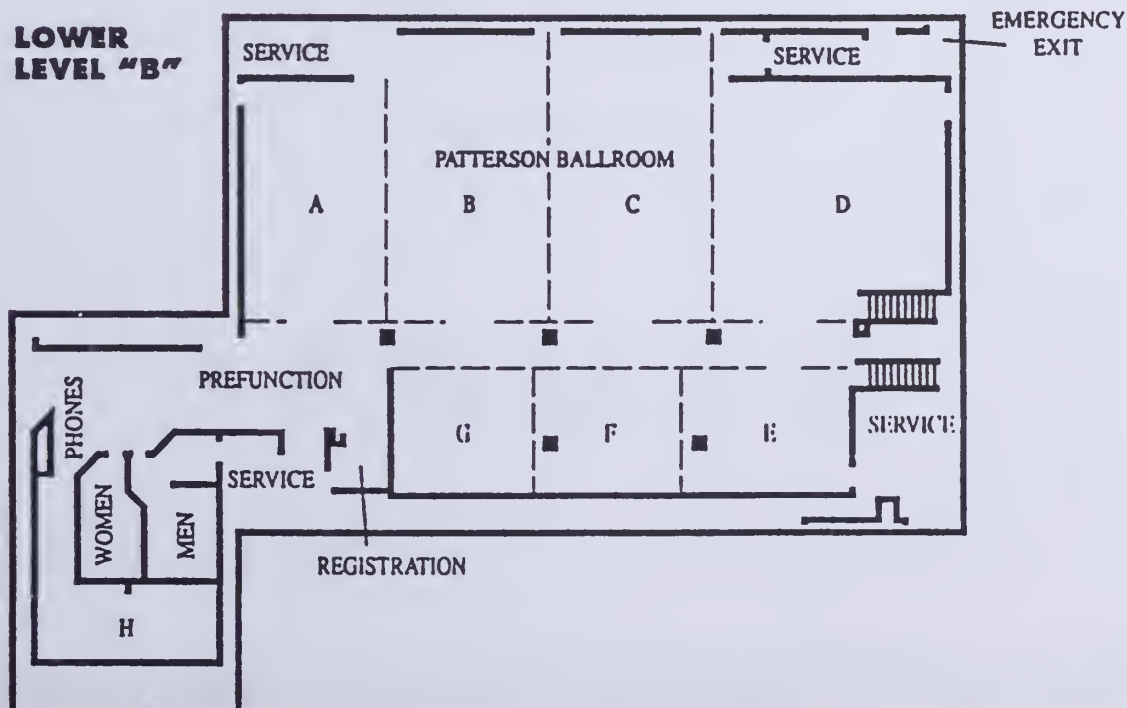


### LOWER LEVEL "A"



## Hyatt Regency Lexington

### LOWER LEVEL "B"





# THE 33<sup>RD</sup> ANNUAL KEMPAC SEMINAR-DINNER



*Larry Forgy*



*Paul Patton*

**FEATURING PRESENTATIONS BY 1995 GUBERNATORIAL CANDIDATES  
MR LARRY FORGY (R) AND LT GOVERNOR PAUL PATTON (D)**

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**Date:** Monday, September 18, 1995

**Time:** 6:00 PM EDT – Reception

7:00 PM EDT – Dinner (Program to follow)

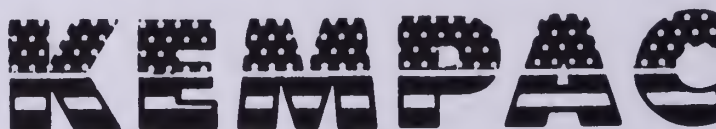
**Place:** Atlanta Room (Reception)

Regency Ballroom (Dinner & Program)

Hyatt Regency Hotel

Lexington, Kentucky

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*Tickets may be purchased from the KEMPAC Headquarters Office for \$30.00 each.  
Please contact the KEMPAC office at (502) 426-6200 or watch the monthly Communicator  
for additional information.*

## **Medical Office and Clinic Staff Claims Prevention Seminar**

Kentucky Medical Insurance Company will offer a special claims prevention seminar for medical office and clinic staff during the KMA Annual Meeting. The 1995 Claims Prevention Seminar was developed specifically for the medical office/clinic staff member. The seminar is a fast-paced program which will address the "Standard of Care". Early registration is essential to allow ample time to complete the self assessment before the seminar.

The cost is \$25 per office/clinic staff member employed by physicians insured by Kentucky Medical. For office/clinic staff whose physician employer is not insured by Kentucky Medical, the cost is \$50 per person.

The seminar is scheduled from 9:00 to 11:00 AM on Tuesday, September 19, 1995, at the Hyatt Regency Lexington. If you would like to request a registration form, please call Kentucky Medical Insurance Company either toll free at 800/467-1858, or in Louisville, 339-5771. *Early registration is encouraged.*

## **Physician Seminar Kentucky Medical Insurance Company's Risk Management Seminar**

Kentucky Medical Insurance Company will be presenting a two-hour Risk Management Seminar on Physician/Patient Communication during the KMA Annual Meeting. The seminar will be held Thursday, September 21, 1995, at the Hyatt Regency Lexington. Lunch will be provided from 12:00 noon until 1:00 pm and the seminar will follow at 1:00 pm and conclude at 3:00 pm. The cost of the seminar is \$50.00 and is open to all physicians.

Physicians insured with Kentucky Medical Insurance will receive 5% premium credit on their next policy renewal for their participation.

The Kentucky Medical Insurance Company is accredited by the Kentucky Medical Association to sponsor continuing medical education for physicians. Kentucky Medical Insurance Company designates this activity for two credit hours in Category I of the Physicians Recognition Award of the American Medical Association Continuing Medical Education Credits.



*"Be Our Guest"*

*If you are a physician age 40 years or younger, or  
if you've been in practice 5 years or less...*

*Be our guest and join your colleagues at a  
luncheon being held during the  
Kentucky Medical Association's Annual Meeting  
Tuesday, September 19, 1995*

*12:00 noon*

*Lexington Room - Hyatt Regency Lexington*

*Space is limited...*

*To make a reservation, call (502) 426-6200*

*(Spouses welcome)*

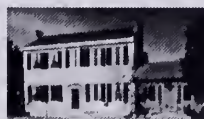
*Make Plans To Attend!*

**MCDOWELL HOUSE, APOTHECARY  
& GARDENS**

**T**he Managers Committee and Staff of the Ephraim McDowell House would like to invite all of those attending the KMA Annual Meeting in Lexington this September to visit this KMA-owned historic house. You will only be a 35-minute drive away from the house where Doctor Ephraim McDowell performed the first successful removal of an ovarian tumor in the world, in 1809. The house is restored and furnished in pre-1830 antiques. The apothecary shop is filled with a collection of late 18th and early 19th century apothecary ware.

While you and your family are this close, do not miss this house where medical history was made. See some of McDowell's instruments, as well as his medicine chest. On your personally guided tour, hear the story of McDowell's family, his medical education, and the story of his surgery on Mrs. Jane Todd Crawford.

The House and Shop have been lovingly restored and protected by the KMA for many years, and furnished beautifully by the KMA Alliance. Do not miss this opportunity while you are so close.



**MCDOWELL HOUSE**  
125 SOUTH SECOND STREET  
DANVILLE, KY 40422  
TELEPHONE: 606/236-2804

**PLAN TO ATTEND THE 1995  
KMA PRESIDENTS  
LUNCHEON**

**WEDNESDAY, SEPTEMBER 20, 1995**

**PATTERSON BALLROOM**

**HYATT REGENCY, LEXINGTON**

**FOR TICKETS OR  
INFORMATION**

**CALL THE KMA  
HEADQUARTERS OFFICE**

**502-426-6200**



## John James Moren, MD 1871–1948

Major concerns of our medical community are reflected in the activities of those members who participate at all levels of the medical societies — local, county, regional and state. Giving much of their time and talent to these endeavors in addition to full-time service to the patient community, many of these vigorous members serve as medical society presidents. John James Moren, MD, the medical gentleman whom we honor at this memorial meeting, was such a physician.

Moren was born on 31 August 1871 in London, Laurel County, Kentucky, the son of William Titus and Mary Frances (Adkins) Moren. His preliminary education was obtained in the London schools. He attended Centre College, Danville, Kentucky, in 1889 and University of Kentucky, Lexington, 1890-1891,<sup>1</sup> before entering Louisville Medical College, receiving his MD there in 1894.<sup>2</sup> He also earned a diploma from the Hospital College of Medicine, Louisville, 1895.<sup>3</sup> In this year his name first appears in *Carson's Directory*... as "Moren, John J., physician..."<sup>4</sup>

Upon graduation, he assumed teaching responsibilities at The Hospital College of Medicine as Assistant in the Neurologic Clinic. This experience and that as Instructor in the same clinic in 1898, securely focused his attention on neurology as a specialty.<sup>5</sup>

As was customary for those graduates desiring to broaden their scope of knowledge of medicine, Dr Moren sought further education in other metropolitan areas, attending The New York Polyclinic for postgraduate work in neurology in 1899. Three years later (1902), he attended postgraduate lectures in London, England, at the Hospital for Paralyzed and Epileptic.<sup>6</sup> It may have been during this overseas period that he purportedly attended clinics in Berlin, Germany, although there is no direct evidence of this.<sup>7</sup>

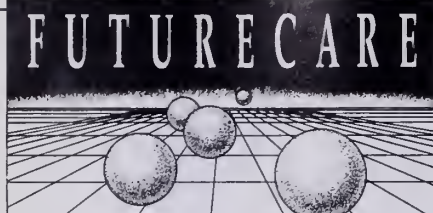
Upon his return from Europe he was soon appointed Professor of Diseases of the Nervous System and Lecturer in Medical Jurisprudence in the Hospital College of Medicine and Consultant Neurologist at the Louisville City Hospital. He then resumed his active participation in the affairs of the medical community.<sup>8</sup> He was a member of the Falls City Medical Society and a member (1898-1904) and one-time Secretary of the short-lived Practitioners Club.<sup>9</sup>

Since the Jefferson County Medical Society had been revived in 1902, there were certain deficiencies in its Constitution and Bylaws that did not provide for regular meetings nor did it fully represent the medical community in which a number of medical societies had proliferated and prospered. Upon his re-

turn to Louisville, Dr Moren joined the Jefferson County Medical Society (JCMS). By the spring of 1905, he, James B. Bullitt, MD, and Louis Frank, MD, were appointed a committee to rewrite the Constitution and Bylaws upon the model proposed by the Reorganization Committee of the AMA.<sup>10</sup> This task was accomplished, presented to and adopted by the JCMS. On December 19, 1905, Dr Moren was elected President of the reorganized JCMS.<sup>11</sup> He soon recognized there were an increasing number of malpractice cases in the community and it was from these observations and the solution he sought that his lasting interest and outstanding contributions to the medical profession were generated.

Expanding the scope of his studies of malpractice cases beyond the confines of Jefferson County, he spoke throughout the state at county and regional medical society meetings about malpractice and the Medical Defense Branch, later known as the Medico-Legal Committee of the KMA. He had cultivated a fine working relationship with several attorneys in Jefferson County. Early in 1909, Edward W. Hines, Esq., of Jefferson County, became Counsel and Dr Moren Chairman of the Medical Defense Branch of the KMA.<sup>12-14</sup> The Medical Defense Branch of KMA had been adopted at the Annual Meeting held in





Winchester, Kentucky, in October 1908. The object of this newly-created branch of KMA "was to furnish to members of the state society, defense against unjust malpractice suits."<sup>15, 16</sup> Membership in the Medical Defense Branch was entirely voluntary and the fees were \$5 initiation, and \$1/year dues. This system for addressing the problem of increasing medical malpractice suits had been effective in other states and was copied initially from the British, who inaugurated it in 1885.<sup>17</sup>

Dr Moren continued his work on behalf of his fellow practitioners and each year at the Annual meetings had presented a summary of the year's work.<sup>18, 21</sup> In 1916, he summarized the lessons learned and observations made by the Committee.<sup>22</sup>

In addition to his duties with the Medical Defense Branch, later known as the Medico-Legal Committee, he was elected President of the KMA at Newport, Kentucky, in September 1914. He served with distinction during the difficult period of the prodromes of WWI.

Dr Moren was an active participant in the Medico-Chirurgical Society [Louisville] (5 Feb 1909 — 12 Feb 1932) and presented a number of papers and contributed much to the discussion of those presented by others. Upon his resignation from active membership after nearly a quarter of a century, his colleagues accorded him honorary membership.<sup>23</sup> He frequently offered discussion of papers presented at local, regional and state society meetings as well as addressing his colleagues on such topics as "Electrical Examination,"<sup>24</sup> "Neuritis,"<sup>25</sup> "Diagnosis of Paralysis in Childhood,"<sup>26</sup> and "Drink Plenty of Water."<sup>27</sup> A complete bibliography of his writings has not been made.

When the medical schools became consolidated into the University of Louisville Medical Department, Dr Moren was appointed Adjunct Professor of Nervous and Mental Diseases, 1908-1923; Assistant Clinical Professor of Neurology, 1923-1928; Clinical Professor of Neurology and Head of the Department, 1928-1940;<sup>28</sup> he became Pro-

fessor Emeritus in 1940.<sup>29</sup>

During WWI, he served as a major in the US Army Medical Reserve Corps, AEF. During WWII he was an examiner of military inductees.

Throughout over 50 years of active practice he served patients and colleagues at St. Joseph's and The Norton Memorial Infirmaries, Louisville City Hospital, Jewish Hospital, Children's Hospital and the Masonic Home. He had maintained an office and residence on West Chestnut St, following graduation in medicine until his marriage to Miss Ferda Zorn Norton<sup>30</sup> on August 5, 1907, when he moved both residence and office to the Weissinger-Gaulbert Buildings on West Broadway.

On Tuesday, 27 October 1948, he died at the Nichols General (VA) Hospital of hepatic insufficiency.<sup>31, 32</sup> His wife Ferda (d. 25 January 1943), had predeceased him and they had no children. They are buried in Cave Hill Cemetery.<sup>33, 34</sup>

It is appropriate that we memorialize such an individual who personified the courageous, kindly and understanding practitioner serving patients, students and colleagues throughout his lifetime.

**Eugene H. Conner, MD**  
KMA Historian

## References

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2. *Annual Announcement of the Louisville Medical College, Louisville, KY*, session of 1894-95, Louisville, KY: John P. Morton Co; 1894:24.
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4. Caron CK, Publisher. *Caron's Directory of the City of Louisville for 1895*. Vol 25 p 784. [The title of Caron's Directory varies slightly but CK Caron continuously published this Directory until 1917.]
5. *The Hospital College of Medicine, Louisville, KY. Medical Department of the Central University of Kentucky Announcement for 1898. Catalogue for 1897*. p 2. 24th Annual Session begins January 3, 1898. np nd [Moren lecturer on diseases of NS &

Asst to the Chair of the Principles and Practices of Medicine and Clinical Medicine.]

6. *University of Louisville Bulletin*. 1922:16:14.
7. Vide supra #1 p 292.
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9. Polk RL. *Polk's Medical and Surgical Register and Directory of the United States and Canada*, 7th revised ed. Detroit, Baltimore and Chicago: RL Polk & Co; 1902:835.
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13. Moren JJ. Medical Defense. *KMJ*. 1909;7:170-173.
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18. Vide Supra #15. This may be considered the First Annual Report.
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23. MSS minutes of Medico-Chirurgical Society [Louisville]. 1906-1927. Archives UL Kornhauser Medical Library; MSS Minutes of Medico-Chirurgical Society [Louisville]. Jan 1932-Dec 1932. Archives UL Kornhauser Medical Library.
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27. ——— Drink Plenty of Water. *KMJ*. 1915;13:121-125.
28. Vide Supra #6 p 14.
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## Introducing the Annual Meeting Speakers



**F. Douglas Scutchfield, MD**  
San Diego, CA  
Director, Graduate School of Public Health, San Diego State University; Clinical Professor, Department of Family & Community Medicine, University of California, MD, 1966, University of Kentucky. Diplomate, American Board of Preventive Medicine. Fellow, American Academy of Family Practice, American College of Preventive Medicine, Royal Society for Health.



**Rodney A. Appell, MD**  
Cleveland, OH  
Head, Section of Voiding Dysfunction & Female Urology, Cleveland Clinic Foundation. Clinical Professor of Urology, Louisiana State University School of Medicine, New Orleans. MD, 1973, Jefferson Medical College, Philadelphia. Diplomate, National Board of Medical Examiners, and American Board of Urology. Fellow, American College of Surgeons.



**Diane E. Schuller, MD**  
Danville, PA  
Director, Department of Pediatric Allergy, Immunology and Pulmonary Diseases, Geisinger Medical Center, Danville; Clinical Professor of Pediatrics, Thomas Jefferson University Medical College, Philadelphia. MD, 1970, State University of New York, Downstate Medical College, Brooklyn. President-Elect, American College of Allergy and Immunology.



**Jack L. Cronenwett, MD**  
Lebanon, NH  
Professor of Surgery, Department of Surgery, Dartmouth Medical School; Chief, Section of Vascular Surgery, Dartmouth-Hitchcock Medical Center, Hanover. MD, 1973, Stanford University, Stanford, California. Traveling Fellow, Australia and New Zealand Chapter of the American College of Surgeons. Fellow, International Society for Cardiovascular Surgery.



**Sheldon F. Markel, MD**  
Ann Arbor, MI  
Member, Department of Pathology, Joseph Mercy Hospital, Ann Arbor. MD, 1961, University of Michigan Medical School, Ann Arbor. President, Michigan Society of Pathologists. Founding member and Executive Vice President of Huron Valley Physicians Association.



**James F. Donohue, MD**  
Chapel Hill, NC  
Professor, University of North Carolina School of Medicine, Chapel Hill. MD, 1969, University of Medicine and Dentistry of New Jersey, Newark. Fellow, American College of Chest Physicians and American College of Physicians. Past President, Southern Chapter, American College of Chest Physicians.



**George Blankenship, MD**  
Hershey, PA  
Professor and Chairman, Ophthalmology Department and Associate Dean for External Affairs and Continuing Medical Education, Penn State College of Medicine, Hershey. MD, 1966, Tulane University, New Orleans.



**John Goff, MD**  
Arvada, CO  
Affiliate of Gastroenterology Associates; Clinical Professor of Medicine, University of Colorado, Denver. MD, 1975, University of California. American College of Gastroenterology Governor, Colorado, and Region V Regional Councilor.



**Bruce H. Thiers, MD**  
Charleston, SC  
Professor of Dermatology, Medical University of South Carolina, Charleston; Associate Editor of the *Journal of the American Academy of Dermatology*. MD, 1974, State University of New York at Buffalo School of Medicine.



**Jeffrey L. Apfelbaum, MD**  
Northbrook, IL  
Associate Professor and Vice Chair, Clinical Affairs, and Director, Outpatient Surgery, The University of Chicago Hospitals and Clinics. MD, 1978, Northwestern University, Chicago. Past President, Society for Ambulatory Anesthesia.

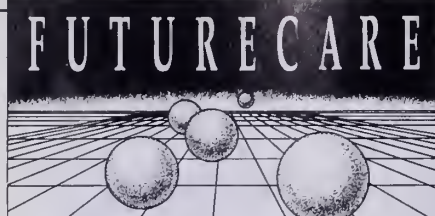


**Sally L. Brooks, MD**  
Cincinnati, OH  
Assistant Professor, Department of Family Medicine, University of Cincinnati; Medical Director, Transitional Care and Home Health Services, Christ Hospital, Cincinnati. MD, 1988, Marshall University, Huntington, W VA.



**Vernon L. Young, MD**  
St. Louis, MO  
Professor of Surgery, Plastic and Reconstructive, Washington University School of Medicine, St. Louis. MD, 1970, University of Kentucky. Vice President, St. Louis Area Society of Plastic Surgeons.





**Shirley M. Neitch, MD**  
Huntington, WV

Associate Professor of Medicine and Chief, Section of Geriatrics, Marshall University School of Medicine, Department of Internal Medicine, Huntington, WV. MD, 1977, Medical College of Virginia. Diplomate, American Board of Internal Medicine. Fellow, American College of Physicians; Founding Fellow, Southern Society for Geriatric Medicine.



**Sherman Elias, MD**  
Houston, TX

Henry and Emma Meyer Chair in Obstetrics and Gynecology; Professor, Obstetrics and Gynecology; Professor, Molecular and Human Genetics, Baylor College of Medicine, Houston. MD, 1972, University of Kentucky College of Medicine. Fellow, American College OB/GYN, American College of Medical Genetics, and American Fertility Society.



**Robert M. Suskind, MD**  
New Orleans, LA

Professor and Chairman, Department of Pediatrics, Louisiana State University Medical Center, New Orleans; Advisory Board of the International Institute for Infant Nutrition and Gastrointestinal Disease of the Children's Hospital of Buffalo, NY. MD, 1963, University of Pennsylvania School of Medicine, Philadelphia.



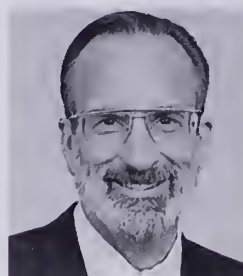
**William L. Healy, MD**  
Burlington, MA

Chairman, Department of Orthopaedic Surgery, Lohey Clinic, Burlington; Associate Clinical Professor, Boston University School of Medicine. MD, 1978, State University of New York, Brooklyn. Member, American Academy of Orthopaedic Surgeons/Japanese Orthopaedic Association/Japanese-American Exchange Fellow, 1992.



**Gail J. Povar, MD**  
Bethesda, MD

Clinical Professor of Medicine and of Health Care Sciences, George Washington University School of Medicine and Health Sciences, Washington, DC. MD, 1977, University of Vermont College of Medicine, Burlington. Diplomate, National Board of Medical Examiners. Fellow, Kennedy Institute of Ethics, Georgetown University.



**Arthur H. White, MD**  
Daly City, CA

Medical Director, San Francisco Spine Institute; Medical Director, SpineCore Medical Group. MD, 1965, University of California, Irvine. Past President, North American Spine Society. Founder of California Back School and St. Mary's Spine Center in San Francisco, and instrumental in founding North American Spine Society.



**Albert L. Rhoton, Jr, MD**  
Gainesville, FL

R.D. Keene Family Professor and Chairman, Department of Neurological Surgery, University of Florida, Gainesville. MD, 1959, Washington University School of Medicine, St. Louis. Past President, American Association of Neurological Surgeons, and Congress of Neurological Surgeons.



**Robert A. Bitterman, MD, JD**  
Charlotte, NC

Director of Risk Management & Managed Care, Coordinator of Medical Student Education, Department of Emergency Medicine, Carolinas Medical Center, Charlotte. MD, 1976, Wayne State University School of Medicine, Detroit. JD, 1994, University of Detroit Law School. Diplomate, American Board of Emergency Medicine. Fellow, American College of Emergency Physicians.

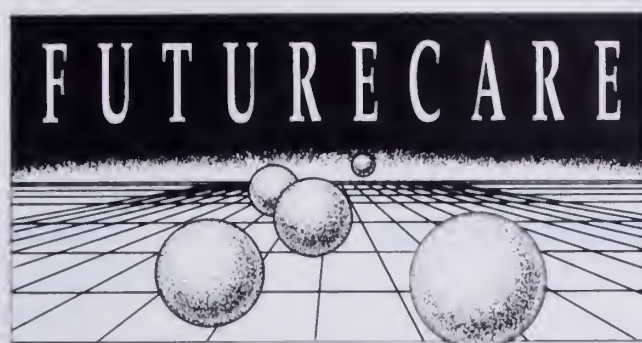
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**Paula Sundance, MD**  
Concord, CA

VP, Paradigm Health Corp, Concord; Director, Regional Rehab, The Permanente Medical Group, Kaiser Foundation Health Plan, Vallejo, CA. MD, 1985, University of California School of Medicine, San Diego, La Jolla, CA. Diplomate, American Academy of Physical Medicine and Rehabilitation.

**Thomas W. McAllister, MD**  
Concord, NH

Associate Professor of Psychiatry, Dartmouth Medical School, Hanover, NH. MD, 1978, Dartmouth Medical School. Member, National Head Injury Foundation. Examiner, American Board of Psychiatry and Neurology.



Kentucky Medical Association

## Scientific Program

John J. Moren, MD, Meeting

### Robert R. Goodin, MD KMA President, Presiding

Tuesday, September 19, 1995  
Morning General Session  
General Sessions Area  
Lexington Center

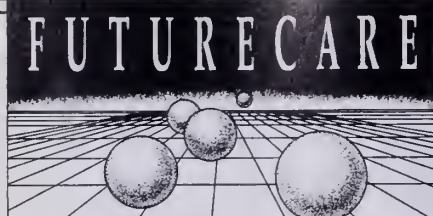
- 8:30 AM Opening Ceremonies
- 8:40 AM **Abdominal Aortic Aneurysms: When is Surgery Cost Effective?**  
Jack L. Cronenwett, MD, Lebanon, NH
- 9:00 AM **Prenatal Diagnosis Using Fetal Cells Isolated from Maternal Blood**  
Sherman Elias, MD, Houston, TX
- 9:20 AM **Urinary Incontinence 1995 and Beyond**  
Rodney A. Appell, MD, Cleveland, OH
- 9:40 AM **Treatment of Trigeminal Neuralgia and Hemifacial Spasm**  
Albert L. Rhoton, Jr., MD, Gainesville, FL
- 10:00 AM **Intermission to visit exhibits**
- 10:30 AM **Prevention of Blindness by Detection of Diabetic Retinopathy**  
George Blankenship, MD, Hershey, PA
- 10:50 AM **Impact of Litigation and Regulatory Agencies on the Availability of Medical Devices**  
Vernon Leroy Young, MD, St. Louis, MO
- 11:10 AM **Update on Asthma**  
James F. Donohue, MD, Chapel Hill, NC
- 11:30 AM **Economic Considerations in Total Joint Arthroplasty: A Dilemma for Surgeons and Hospitals**  
William L. Healy, MD, Burlington, MA

### KY OB/GYN Society — KY Section ACOG

Lexington Center  
Meeting Room — Ballroom 2  
Tuesday, September 19, 1995

- 10:30 AM OB/GYN Advisory Committee Meeting —  
Patterson G, Hyatt Regency Hotel
- 12:00 NOON Luncheon — Patterson B, Hyatt Regency Hotel
- 1:30 PM **Current Concepts in Maternal Serum Screening for Fetal Genetic Disorders**  
Sherman Elias, MD, Houston, TX
- 2:10 PM **New Concepts and Therapy for the Menopause**  
Kenneth N. Muse, MD, Lexington, KY
- 2:40 PM **Utility of Glucose Screening in Pregnancy and its Implications**  
Berry A. Campbell, MD, Lexington, KY
- 3:10 PM **Questions and Answers**
- 3:20 PM **Intermission to visit exhibits**
- 3:40 PM **Advances in Ovarian Cancer Screening**  
John R. van Nagell, Jr, MD, Lexington, KY
- 4:10 PM **New Approaches to the Management of Recurrent Urinary Stress Incontinence**  
Michael H. Heit, MD, Louisville, KY
- 4:40 PM **Questions and Answers**
- 5:00 PM Adjournment





## KY Chapter, American College of Surgeons

Lexington Center  
Meeting Room — Ballroom 4  
Tuesday, September 19, 1995

- 11:00 AM Kentucky Chapter Council Meeting —  
Patterson E, Hyatt Regency Hotel
- 12:00 NOON Kentucky Chapter Luncheon (members  
guests) — Patterson D, Hyatt Regency Hotel
- 1:30 PM **A Surgeon's Perspective on Outcomes  
Assessment**  
Jack L. Cronenwett, MD, FACS, Lebanon,  
NH
- 2:00 PM **Implementing Total Quality Management  
in an Academic Surgery Setting: Lessons  
Learned**  
Byron Young, MD, FACS, Lexington, KY
- 2:25 PM **Quality Assessment From Large Data  
Bases: Professional Input is Mandatory**  
J. David Richardson, MD, FACS, Louisville,  
KY
- 2:50 PM **Quality Considerations in the Practice of  
Carotid Endarterectomy**  
Charles B. Ross, MD, Paducah, KY
- 3:05 PM **Surgery in an Eastern Kentucky  
Community**  
Richard W. Proudfoot, MD, FACS,  
Morehead, KY
- 3:20 PM **Intermission to visit exhibits**
- 3:30 PM **The Making of a Rural Surgeon — Should  
our Training Programs Differ?**  
M. Todd Marion, MD, Glasgow, KY
- 3:45 PM **Cost Containment, Negative Outcomes,  
and Nonreimbursability**  
Michael A. Rie, MD, Lexington, KY
- 4:00 PM **The Peer Review Process in Kentucky**  
William H. Mitchell, MD, FACS, Richmond,  
KY
- 4:15 PM **Critical Pathways for Coronary Artery  
Surgery**  
Robert M. Groves, MD, FACS,  
Madisonville, KY
- 4:30 PM **Utilization of Resources for Treatment of  
Abdominal Aortic Aneurysms:  
Demographic Considerations**  
Thomas H. Schwarcz, MD, FACS,  
Lexington, KY
- 4:45 PM **The Role of a Multidisciplinary Breast  
Center in Cost Effective Management of  
Breast Cancer**  
Patrick C. McGrath, MD, FACS, Lexington,  
KY

## KY Neurosurgical Society

Lexington Center  
Meeting Room — E  
Tuesday, September 19, 1995

- 1:00 PM **Anatomy and Syndromes of the Posterior  
Cranial Fossa**  
Albert L. Rhoton, Jr, MD, Gainesville, FL
- 2:00 PM **Intraventricular Hemorrhage in the  
Neonate**  
Andrew Reisner, MD, Louisville, KY
- 2:15 PM **A Comparison of Radiosurgery with  
Conventional Treatment of Brain  
Metastasis**  
Warren W. Boling, MD, Lexington, KY
- 2:30 PM **Intermission to visit exhibits**
- 2:45 PM **Colloid Cysts of the Third Ventricle: A  
Transcallosal Approach**  
John J. Guarnaschelli, MD, Louisville, KY
- 3:00 PM **Management of Fractures to the Thoracic  
Spine**  
Deborah A. Blades, MD, Lexington, KY
- 3:15 PM **Approaches to Tentorial Meningiomas**  
Susanne E. Fix, MD, Louisville, KY
- 3:30 PM **Adult Tethered Cord Syndrome —  
Controversies in Management**  
David A. Petruska, MD, Louisville, KY
- 3:45 PM **Minimally Invasive Neurosurgery**  
Jonathan E. Hodes, MD, Lexington, KY
- 4:00 PM **Fifty Years of Neurosurgery at the  
University of Louisville**  
Christopher B. Shields, MD, Louisville, KY
- 4:15 PM **State Acute Low Back Pain Practice  
Guidelines**  
James R. Bean, MD, Lexington, KY
- 4:30 PM **Data Acquisition Relative to the  
Reimbursement Status in Kentucky**  
Lansing S. Cowles, MD, Louisville, KY
- 5:00 PM **Business Meeting**

## KMA Medical Student Section & KMA Resident Physician Section

Lexington Center  
Meeting Room — Ballroom 3  
Tuesday, September 19, 1995

- 1:00 PM **Opening and Welcome**  
Presidents of the two Sections
- 1:15 PM **Welcome from KMA**
- 1:20 PM **Welcome from AMA-RPS**
- 1:30 PM **Managing to Care in a Managed Care Environment**  
Beverly Gaines, MD, Member, Kentucky Health Policy Board  
James E. Hartert, MD, Chief Medical Officer, Humana Health Care Plans of KY  
Wm. P. VonderHaar, MD, KMA Secretary-Treasurer
- 2:30 PM **Question & Answer Session**

## KY Academy of Eye Physicians and Surgeons

Lexington Center  
Meeting Room — C  
Tuesday, September 19, 1995

- 1:30 PM **Current Management of Diabetic Retinopathy**  
George Blankenship, MD, Hershey, PA
- 2:00 PM **State and Federal Affairs, American Academy**  
William Rich, MD, Fairfax, VA
- 3:00 PM **Intermission to visit exhibits**
- 3:30 PM **CMV Retinitis in Patients with Hemophilia**  
George Blankenship, MD, Hershey, PA
- 4:00 PM **Business Meeting**
- 5:00 PM **Adjournment**

## KY Urological Association

Lexington Center  
Meeting Room — A  
Tuesday, September 19, 1995

- 1:30 PM **Business Meeting**
- 2:15 PM **Advances in Stress Urinary Incontinence**  
Rodney A. Appell, MD, Cleveland, OH
- 3:15 PM **Intermission to visit exhibits**
- 3:45 PM **Pyelogram Hour**
- 4:45 PM **Adjournment**

## KY Chapter, American College of Chest Physicians

Lexington Center  
Meeting Room — F  
Tuesday, September 19, 1995

- 1:30 PM **Recent Advances in COPD**  
James F. Donohue, MD, Chapel Hill, NC
- 2:15 PM **What's New in Tobacco Control**  
David Mannino, MD, Atlanta, GA
- 3:00 PM **Intermission to visit exhibits**
- 3:30 PM **Endothelial Factors in Myocardial Ischemia**  
Robert N. Schnitzler, MD, San Antonio, TX
- 4:15 PM **Management of Patients at Risk for Sudden Cardiac Death. Drugs or Devices?**  
Peter L. Friedman, MD, PhD, Boston, MA
- 5:00 PM **Adjournment**

## KY Society for Plastic & Reconstructive Surgeons

Lexington Center  
Meeting Room — B  
Tuesday, September 19, 1995

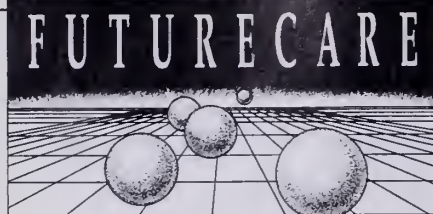
- 1:30 PM **TBA**

### CME

#### AMERICAN ACADEMY OF FAMILY PHYSICIANS

*This program has been reviewed and is acceptable for 16 Prescribed hours by the AAFP. AAFP Prescribed credit is accepted by the AMA as equivalent to AMA PRA Category 1 for the AMA Physicians Recognition Award. When applying for the AMA PRA, Prescribed hours earned must be reported as Prescribed hours, not as Category 1.*





## KY Orthopaedic Society

Lexington Center  
Meeting Room — D  
Tuesday, September 19, 1995

- 1:30 PM Welcoming Comments  
Patrick J. Serey, MD, Morehead, KY
- 1:35 PM **Methods for Cost Control in TJA**  
William L. Healy, MD, Burlington, MA
- 2:00 PM **Clinical Outcome Results and Patient Satisfaction After ACL Surgery**  
R. John Ellis, Jr, MD, Louisville, KY
- 2:15 PM **Current Status of Pedicle Screws**  
Richard T. Holt, MD, Louisville, KY
- 2:30 PM **Surgical Treatment of Spine Deformities with "Wrightlock"**  
John R. Johnson, MD, Louisville, KY
- 2:45 PM **Infection Rate and Associated Factors for Elective Outpatient Extremity Surgery in a Multiple Occupancy Surgical Suite**  
James M. Kleinert, MD, Louisville, KY
- 3:00 PM Intermission to visit exhibits
- 3:30 PM **Do Cemented Cups Really Cost Less?**  
Lawrence A. Schaper, MD, Louisville, KY
- 3:45 PM **Cost Containment in Medicine: Analysis of Cost Shifting with a Theoretical Model of Correction**  
Thomas M. Loeb, MD, Louisville, KY
- 4:00 PM **The Use of an Antibiotic Spacer in THA Sepsis**  
Donald L. Pomeroy, MD, Louisville, KY
- 4:15 PM **Patient Access Coalition**  
Todd Gedville, AAOS, Chicago, IL and Joseph J. Dobner, MD, Frankfort, KY
- 4:45 PM **Councilor's Report**  
Scott B. Scutchfield, MD, Danville, KY
- 4:55 PM **Business Meeting**  
Patrick J. Serey, MD, President, Morehead, KY
- 5:30 PM Adjournment
- 6:00 PM Reception & Dinner — The Lafayette Club atop Bank One, Lexington, KY

## KY Chapter American College of Cardiology

Patterson A, Hyatt Regency Hotel  
Tuesday, September 19, 1995

- 5:00 PM Business Meeting & Reception
- 7:00 PM Adjournment

## Sonia R. Teller, MD Chair Scientific Program Committee Presiding

Wednesday, September 20, 1995  
Morning General Session  
General Sessions Area  
Lexington Center

- 8:30 AM Opening Ceremonies
- 8:40 AM **Surviving Managed Care**  
Arthur H. White, MD, Daly City, CA
- 9:00 AM **Integration of Physicians, Hospitals, and Other Health Care Services — A Strategy for Future Care**  
Sheldon F. Markel, MD, Ann Arbor, MI
- 9:20 AM **Futile Care**  
Gail J. Povar, MD, MPH, Silver Spring, MD
- 9:40 AM **The Malnourished Child**  
Robert M. Suskind, MD, New Orleans, LA
- 10:00 AM Intermission to visit exhibits
- 10:30 AM **Post Concussion Syndrome**  
Thomas W. McAllister, MD, Lebanon, NH
- 10:50 AM **The Impact of Managed Care on Private Practice**  
Serge Martinez, MD, West Springfield, MA
- 11:10 AM **Preoperative Laboratory Testing for Outpatient Surgery**  
Jeffrey L. Apfelbaum, MD, Chicago, IL
- 11:30 AM **Red Flags in Asthma**  
Diane E. Schuller, MD, Hershey, PA

## President's Installation & Awards Luncheon

Wednesday, September 20, 1995 -- 11:50 am  
Patterson Ballroom - Hyatt Regency Hotel

### Robert R. Goodin, MD

KMA President, presiding  
Invocation  
Recognition

Awards Presentation

Nelson B. Rue, MD, Bowling Green

Chair, KMA Awards Committee

Installation of Danny M. Clark, MD

KMA President 1995-96

**KY Pediatric Society**

Lexington Center  
Meeting Room — Ballroom 2  
Wednesday, September 20, 1995

- 2:15 PM **Recent Advances in the Treatment of Childhood Obesity**  
Robert M. Suskind, MD, New Orleans, LA
- 3:15 PM **Intermission to visit exhibits**
- 3:45 PM **The Importance of Glucose Control in Childhood and Adolescent Diabetes**  
Michael B. Foster, MD, Louisville, KY
- 4:15 PM **Potential Risks and Benefits of Routine Lipid Screening in Children**  
Jackson W. Smith, MD, Lexington, KY
- 4:45 PM **Adjournment**

**KY Psychiatric Association**

Lexington Center  
Meeting Room — C  
Wednesday, September 20, 1995

- 2:00 PM **Business Meeting**
- 2:15 PM **Neuropsychiatric Aspects of Delusions**  
Thomas W. McAllister, MD, Lebanon, NH
- 3:15 PM **Intermission to visit exhibits**
- 3:30 PM **Manic Depression**  
Rifaat S. El-Mallakh, MD, Louisville, KY
- 4:30 PM **Adjournment**

**KY Chapter, American College of Physicians**

Lexington Center  
Meeting Room — Ballroom 4  
Wednesday, September 20, 1995

- 2:00 PM **Associates Presentation**
- 2:45 PM **Development — Practice Guidelines**  
Charles C. Smith, MD, FACP, Louisville, KY
- 3:15 PM **Intermission to visit exhibits**
- 3:30 PM **Ethical Considerations of Practice Guidelines**  
Gail J. Povar, MD, MPH, Silver Spring, MD
- 4:15 PM **Practical Consideration of Practice Guidelines**  
Lloyd W. Kitchens, MD, FACP, Dallas, TX
- 4:45 PM **Questions and Answers**
- 5:00 PM **Adjournment**

**KY Chapter, American Academy of Family Physicians/KY Occupational Medical Association**

Lexington Center  
Meeting Room — Ballroom 3  
Wednesday, September 20, 1995

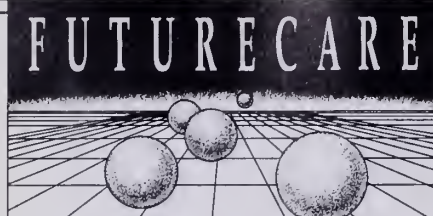
- 2:15 PM **Evaluation and Treatment of Low Back Pain in the Managed Care Environment**  
Arthur H. White, MD, Daly City, CA
- 3:00 PM **Questions and Answers**
- 3:15 PM **Intermission to visit exhibits**
- 3:45 PM **Use of Joint Injections in the Primary Care Setting**  
Paul D. Schneider, MD, Louisville, KY
- 4:30 PM **Integrated Approach to Sleep Management**  
James Keith Barnes, MD, Louisville, KY
- 4:45 PM **Adjournment**

**KY Society of Anesthesiologists**

Lexington Center  
Meeting Room — D  
Wednesday, September 20, 1995

- 2:15 PM **Pain Management in the Ambulatory Surgery Center**  
Michael G. Cassaro, MD, Louisville, KY
- 2:55 PM **Economic Issues in an Outpatient Surgical Center**  
Clair S. Weenig, MD, Lexington, KY
- 3:35 PM **Current State and Future Directions of Outpatient Anesthesia**  
Jeffrey L. Apfelbaum, MD, Chicago, IL
- 4:25 PM **Panel Discussion — Questions and Answers**
- 4:45 PM **Business Meeting**
- 5:15 PM **Reception**
- 6:00 PM **Adjournment**





## KY Society of Pathologists

Lexington Center  
Meeting Room — E  
Wednesday, September 20, 1995

- 2:15 PM **Managed Care and Pathology — I**  
Sheldon F. Markel, MD, Ann Arbor, MI
- 2:45 PM **Managed Care and Pathology — II**  
Sheldon F. Markel, MD, Ann Arbor, MI
- 3:15 PM **Intermission to visit exhibits**
- 3:45 PM **Managed Care: Capitation Issues in Pathology**  
Sheldon F. Markel, MD, Ann Arbor, MI
- 4:15 PM **Questions and Answers**
- 4:45 PM **Adjournment**

## KY Society of Allergy & Clinical Immunology

Lexington Center  
Meeting Room — F  
Wednesday, September 20, 1995

- 1:30 PM **Allergy and Asthma Outcomes**  
Diane E. Schuller, MD, Hershey, PA
- 2:15 PM **Food Allergy**  
Mark L. Corbett, MD, Louisville, KY
- 2:45 PM **Intermission to visit exhibits**
- 3:00 PM **Reactive Airways Dysfunction Syndrome**  
Jonathan A. Bernstein, MD, Cincinnati, OH
- 3:45 PM **Asthma Parameters**  
James L. Sublett, MD, Louisville, KY
- 4:15 PM **Intermission to visit exhibits**
- 4:30 PM **Business Meeting**  
Kentucky Society of Allergy and Immunology
- 5:15 PM **Reception — Patterson E-Hyatt Regency Hotel**

## KY Society of Otolaryngology Head & Neck Surgery

Lexington Center  
Meeting Room — B  
Wednesday, September 20, 1995

- 2:15 PM **TBA**

## Thursday, September 21, 1995

### KY Chapter, American College of Emergency Physicians

Lexington Center  
Meeting Room — E  
Thursday, September 21, 1995

- 9:00 AM **The Future of the Business of Emergency Medicine**  
Robert A. Bitterman, MD, Charlotte, NC
- 10:00 AM **Kentucky ACEP Annual Meeting**
- 11:00 AM **Adjournment**

### KY Association of Public Health Physicians

Lexington Center  
Meeting Room — F  
Thursday, September 21, 1995

- 9:00 AM **The Role of Public Health in an Era of Health Care Reform**  
F. Douglas Scutchfield, MD, San Diego, CA
- 10:30 AM **Intermission to visit exhibits**
- 11:00 AM **Business Meeting**

### KY Academy of Physical Medicine & Rehabilitation

Lexington Center  
Meeting Room — D  
Thursday, September 21, 1995

- 9:00 AM **Annual Business Meeting**
- 9:30 AM **Resident Research Presentations**
- 10:30 AM **Intermission to visit exhibits**
- 11:00 AM **Managing Managed Care: Rehabilitation Strategies in a Limited Resource Environment**  
Paula Sundance, MD, Concord, CA

## KY Society for Gastrointestinal Endoscopy

Lexington Center  
Meeting Room — Ballroom 2  
Thursday, September 21, 1995

### KSGE Research Seminar

- 8:30 AM Welcome and Announcements  
Nicholas J. Nickl, MD, Lexington, KY
- 8:35 AM Research Presentations  
Faculty, Fellows, and Residents  
Departments of Medicine and Surgery  
Universities of Kentucky and Louisville
- 10:00 AM Intermission to visit exhibits  
Clinical Practice Forum  
*Management Of Esophageal Variceal Hemorrhage*
- 10:30 AM Radiologic Approaches and TIPS  
Fang Loh, MD, Lexington, KY
- 10:50 AM Surgical Approaches to Variceal Hemorrhage  
Dinesh Ranjan, MD, Lexington, KY
- 11:10 AM Medical and Endoscopic Approaches to Variceal Hemorrhage: Recent Developments  
John Goff, MD, Denver, CO
- 11:50 AM Questions and Answers  
Lunchtime Topic Seminar  
*Monitoring in Conscious Sedation: Too Much, Not Enough, or Just Right*
- 12:00 NOON Lunch served
- 12:15 PM Monitoring in Conscious Sedation  
Michael F. Heine, MD, Louisville, KY
- 12:35 PM Discussion
- 1:00 PM Adjournment

## KY Dermatological Society

Kentucky Clinic South  
2400 Greatstone Point  
Thursday, September 21, 1995

- 12:30 PM Registration
- 1:00 PM Patient Presentation
- 2:00 PM Break
- 2:30 PM Case Discussion
- 3:30 PM Classification, Evaluation, and Treatment of Cutaneous Lymphomas  
Bruce H. Thiers, MD, Charleston, SC
- 4:30 PM Business Meeting

## KY Geriatrics Society

Lexington Center  
Meeting Room — C  
Thursday, September 21, 1995

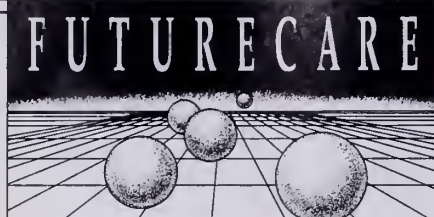
- 8:00 AM Board Meeting
- 9:00 AM Future Care of the Rural Elderly: Still a Forgotten Minority?  
Shirley M. Neitch, MD, FACP, Huntington, WV
- 9:50 AM The Sub-Acute Unit in Geriatric Care  
Sally L. Brooks, MD, Cincinnati, OH
- 10:40 AM Intermission to visit exhibits
- 11:00 AM Caring for the Elderly by Telemedicine  
Joseph A. Florence, MD, Hazard, KY
- 12:00 NOON Business Meeting/Luncheon  
Patterson F — Hyatt Regency Hotel

### CONTINUING MEDICAL EDUCATION

*The Kentucky Medical Association designates this continuing medical education activity for 16 credit hours in Category 1 of the Physician Recognition Award of the American Medical Association. One credit hour may be claimed for each hour of participation by the individual physician.*

The Kentucky Medical Association is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.





## General Sessions Learning Objectives

KY CHAPTER, AMERICAN COLLEGE OF SURGEONS

### ***Abdominal Aortic Aneurysms: When is Surgery Cost Effective?***

Jack L. Cronenwett, MD

The participant should understand which patients warrant ultrasound screening for aneurysms, which patients warrant surgical repair, and when surgical repair is cost effective.

KY NEUROSURGICAL SOCIETY

### ***Treatment of Trigeminal Neuralgia and Hemifacial Spasm***

Albert L. Rhoton, Jr., MD

The participant will learn the elements of diagnosis of trigeminal neuralgia as differentiated from other forms of facial pain; steps in medical management prior to considering surgical treatment; various surgical alternatives in treating trigeminal neuralgia with a focus on stereotactic and microsurgical operations; results of each form of treatment of trigeminal neuralgia; and treatment alternatives with hemifacial spasm.

KY ACADEMY OF EYE PHYSICIANS AND SURGEONS

### ***Prevention of Blindness by Detection of Diabetic Retinopathy***

George Blankenship, MD

The participant will discuss ocular sequelae of diabetic retinopathy; learn to recognize by ophthalmoscopy common retinal findings of diabetes; and review current treatment modalities for diabetic retinopathy.

KY CHAPTER, AMERICAN ACADEMY OF FAMILY PHYSICIANS/KY OCCUPATIONAL MEDICAL ASSOCIATION

### ***Surviving Managed Care***

Arthur H. White, MD

The participant will learn how managed care is affecting the quality and economy of current medical practice; what the individual practitioner can do to survive managed care in the 21st century; how managed care views the individual health care provider; what the individual health care provider can do to best position himself within the new managed care system; what types of managed care systems are evolving and which are likely to succeed; and the four steps that each physician can take at this

time to position themselves for the most likely managed care scenario.

KY UROLOGIC SOCIETY

### ***Urinary Incontinence 1995 and Beyond***

Rodney A. Appell, MD

The participant will review types of urinary incontinence; discuss diagnosis and etiology of urinary incontinence; review standard treatment modalities for urinary incontinence; and discuss the place for new advances in treatment of urinary incontinence.

KY OB/GYN SOCIETY-KY SECTION ACOG

### ***Prenatal Diagnosis Using Fetal Cells Isolated From Maternal Blood***

Sherman Elias, MD

The participant will discuss strategies for isolating and analyzing fetal cells from maternal blood; describe experiences with prenatal detection of Mendelian disorders, fetal gender, and trisomies using fetal cells isolated from maternal blood; and understand future directions in evaluating the feasibility of using fetal cells isolated from maternal blood for prenatal diagnosis.

KY ORTHOPAEDIC SOCIETY

### ***Economic Considerations in Total Joint Arthroplasty: A Dilemma for Surgeons and Hospitals***

William L. Healy, MD

The participant will be presented information on the efficacy, cost effectiveness, and clinical results of total joint arthroplasty and be informed on how hospitals are reimbursed for this procedure.

KY CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

### ***Update on Asthma***

James F. Donohue, MD

The participant will be cognizant of increased dangers of asthma; become familiar with international guidelines for diagnosing and treating asthma; become familiar with inhaled corticosteroids in asthma; and know how to use long acting bronchodilators.

KY PEDIATRIC SOCIETY

### ***The Malnourished Child***

Robert M. Suskind, MD

The participant will understand common causes and approaches to management of malnourishment in children.

KY PSYCHIATRIC ASSOCIATION

### ***Post Concussion Syndrome***

Thomas W. McAllister, MD

The participant will be able to describe the common cognitive deficits of traumatic brain injury; be able to define the usual course of recovery following brain injury; and be able to name three neuropsychiatric sequelae associated with traumatic brain injury.

KY CHAPTER, AMERICAN COLLEGE OF PHYSICIANS

### ***Futile Care***

Gail J. Povar, MD, MPH

The participants will become acquainted with the differing definitions of futility; become acquainted with the ethical implications of these definitions for clinical decision making; and become acquainted with practical approaches to resolving apparent conflicts over "futile care."

KY SOCIETY OF ANESTHESIOLOGISTS

### ***Preoperative Laboratory Testing for Outpatient Surgery***

Jeffrey L. Apfelbaum, MD

The participant will know which laboratory tests should be obtained for patients undergoing outpatient surgery and the rationale for such testing (and nontesting).

KY SOCIETY FOR PATHOLOGISTS

### ***Integration of Physicians, Hospitals, and Other Health Care Services — A Strategy for Future Care***

Sheldon F. Markel, MD

Participant's attention will be brought to the changing demands being placed on the health care system, and to suggest how integration of providers and services might best meet the customer's wants and needs.

KY SOCIETY OF ALLERGY AND CLINICAL  
IMMUNOLOGY

***Red Flags in Asthma***

Diane E. Schuller, MD

To identify factors associated with increased risk of asthma-related death and to provide the audience with criteria for assessment of the asthma patient by history, physical examination, and objective parameters. Case studies and considerations for management will be discussed.

KY SOCIETY FOR PLASTIC AND  
RECONSTRUCTIVE SURGERY

***Impact of Litigation and Regulatory***

***Agencies on the Availability of  
Medical Devices***

V. Leroy Young, MD

The participants will be made aware of the impending shortage of raw materials used in the production of medical devices that has been brought on by product liability litigation and rulings by regulatory agencies. It is hoped that through more general awareness of this impending crisis that pressure will be brought on to legislative bodies to introduce meaningful tort reform to control product liability and modify the authority of the regulatory agencies so that they function in a more positive way. Without these

changes, there will be major shortages of fundamental medical products such as vascular grafts, endotracheal tubes, certain types of catheters and perhaps even sutures.

KY SOCIETY OF OTOLARYNGOLOGY

***The Impact of Managed Care on  
Private Practice***

Serge Martinez, MD

The participant will review the current environment of the managed care arena as it relates to the private practitioner including review of legal, financial, and regulatory aspects.

**AN INVITATION TO ALL SENIOR AND/OR RETIRED MEMBERS OF KMA  
TO THE STATEWIDE CATO SOCIETY MEETING  
OF THE SENIOR PHYSICIANS OF  
JEFFERSON COUNTY**

**9:30 AM**

**WEDNESDAY, SEPTEMBER 20, 1995  
THE HYATT REGENCY HOTEL, LEXINGTON, KY**

**H**ere is an opportunity for senior and/or retired members of KMA to meet old colleagues and make new friends at the 6th Annual Statewide CATO Society Meeting, held during the KMA Annual Meeting. This year the CATO Society meeting will be held at the Hyatt Regency Hotel in Lexington, Kentucky. It will begin with breakfast at 9:30 AM in the Atlanta Room.

The CATO Society is an integral part of the Jefferson County Medical Society and its Senior Physicians Committee. We have meetings in the Spring and Fall that are primarily for fellowship. We gather for a light meal followed by an enlightening but brief address on some informative or entertaining topic.

Last year's meeting was an immense success with a large crowd of senior physicians from the Kentucky area.

This year we cordially invite spouses and widows to attend.

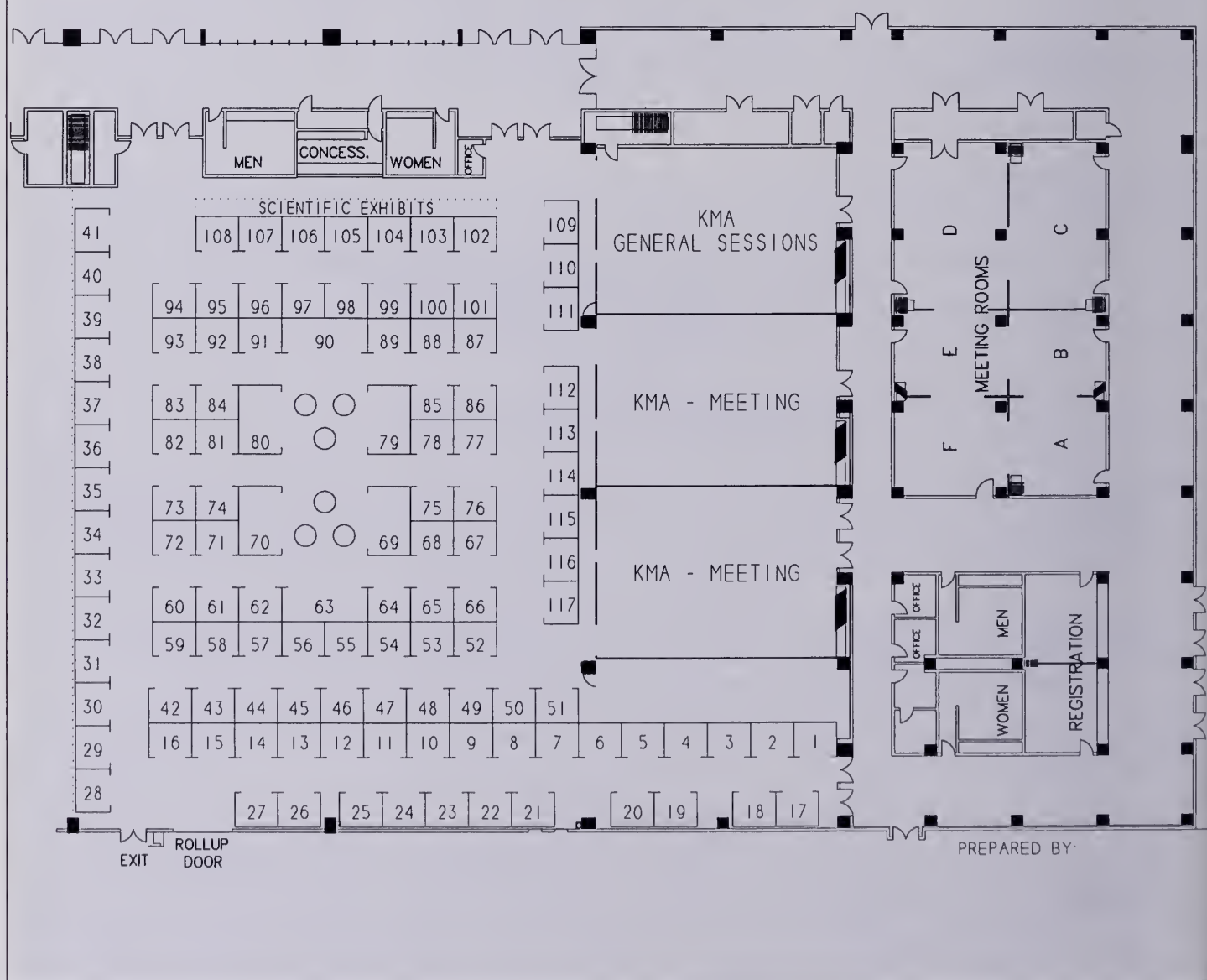
Watch the mail for your invitation, complete the form, and share a time during breakfast with your colleagues. We look forward to visiting with you.

Eugene H. Conner, MD  
President, Jefferson County CATO Society



## EXHIBIT HALL FLOOR PLAN

### LEXINGTON CONVENTION CENTER LEXINGTON, KENTUCKY



All exhibitors with corresponding booth space(s) are listed on this map of the Exhibit Hall. We regret that due to printing and publication deadlines, not all exhibitors are represented in this Exhibit Guide. For more detailed information on the exhibitors, refer to the Technical Exhibits listing beginning on page 371, and please visit them in the Exhibit Hall.

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## TECHNICAL EXHIBITS

**P**lan to visit the Exhibit Hall during the KMA Annual Meeting. Trained professional representatives of more than 100 firms will be on hand to discuss with you the details of their products and services in a relaxed atmosphere — with no patients waiting in your outer office and with no telephones ringing.

Located in the Lexington Center, the exhibits will condense a volume of information and ideas in such a manner that a vast amount of knowledge can be secured in a short period of time.

The Exhibit Hall is an important part of the Annual Meeting and is the site of registration for all CME courses.

Thirty-minute intermissions have been planned during each general and specialty group session so that every physician may take advantage of this opportunity to benefit their practice and their patients.

**Abbott Laboratories** #1  
200 Abbott Park Road  
Abbott Park, IL 60064-3537  
(708) 937-6100  
You are cordially invited to visit the Abbott booth which will feature Biaxin® (clarithromycin) and Hytrin® (terazosin HCl). Please check at the exhibit to see what's new!

**AdminaStar of Kentucky** #69  
9901 Linn Station Road  
Louisville, KY 40223-3824  
Administration (502) 329-8500  
Physician/Provider Customer Service (502) 425-7776  
Medicare Fiscal Intermediary and Carrier for the Commonwealth of Kentucky.

**Alliant Health System** #114  
PO Box 35070  
Louisville, KY 40232-5070  
(502) 629-8652  
— Lighted Skyline Display with Hospital Logo  
— Printed Brochures and pamphlets of services and physician information  
— Alliant Logo and promotional items will be displayed on a table for distribution  
— Registered Nurses from the Physician Services Department will be in attendance.

**AllMed Financial Corp** #60  
8910 Purdue Rd  
Indianapolis, IN 46268  
(317) 228-5140  
AllMed Financial Corp is one of the largest medical receivables management companies in the country. As a subsidiary of The Associated Group (a \$3.5 billion organization focused on health care), AllMed's mission is to de-

liver unparalleled service with competitive terms for today's providers. AllMed's product offerings are consolidated into two specific categories: *Finance* — low cost financing programs for both providers and their patients. *A/R Management* — professional, customer-oriented approach to processing medical receivables. Focusing on the needs of health care providers has separated AllMed from others. Commitment to service, technology and people will continue to differentiate AllMed as we face the changes within the health care industry.

**The Almont Group** #72  
PO Box 37  
Simsbury, CT 06070  
(800) 289-9207  
We are financial planners who specialize in qualified and non-qualified pension programs for medical practitioners. Unless careful planning is done while you are working, the IRS will receive a larger portion of your retirement plan's assets than you will. We can help.

**Appalachian Regional Healthcare, Inc** #20  
1220 Harrodsburg Rd, PO Box 8086  
Lexington, KY 40533  
(606) 281-2528  
Appalachian Regional Healthcare, Inc is a not-for-profit healthcare system which includes 11 hospitals, 12 primary care clinics and 10 home care agencies in eastern Kentucky, West Virginia, and Virginia. We are seeking primary care and specialty physicians who desire to affiliate with one or more of our facilities. There are solo, group and salaried practices available. Stop by Booth #20 and let's discuss opportunities with

ARH.

**Astra Merck, Inc** #75  
5110 Maryland Way, Suite 190  
Brentwood, TN 37027  
(615) 371-5288  
Astra Merck, Inc is dedicated to revolutionizing the pharmaceutical industry by being the best at linking patients and products through unique, responsive, customer-shaped pharmaceutical solutions. Our commitment is to provide customized services and new programs designed to meet local and national issues along with quality products.

**Bank of Louisville** #15  
500 West Broadway  
Louisville, KY 40201  
(502) 562-5884  
Private Banking services offered to a select group of individuals. Services include checking, savings, special low interest loans, personal lines of credit, and trust and investment services. Designed to cater to every banking need with personal service from your representative and special offers from your financial institution. One on one individualized service ensures that your needs are well looked after and that you achieve your financial goals with a minimum of effort.

**Baptist Healthcare System** #85  
4007 Kresge Way  
Louisville, KY 40207  
(502) 896-5000

**Berlex Laboratories** #16  
300 Fairfield Road  
Wayne, NJ 07470  
(201) 305-5082  
Berlex invites you to visit our booth to discuss our line of female healthcare products.

**Cardinal Hill Rehabilitation Hospital #115**

2050 Versailles Road  
Lexington, KY 40504  
(606) 254-5701

Cardinal Hill Rehabilitation Hospital is a nonprofit physical rehabilitation hospital in Lexington, KY. Cardinal Hill has specialized programs to meet the needs of adults and children with all types of disabling conditions. Our inpatient programs include: head injury, spinal cord injury, stroke, and general rehabilitation including amputee and orthopedic. Our outpatient programs include an occupational medicine center, comprehensive pain management, outpatient clinics, and outpatient therapy services for both adults and pediatrics.

**CARETENDERS #2**

9200 Shelbyville Road  
Louisville, KY 40222  
(502) 425-4701

The Caretenders booth illustrates the various home care services provided as part of the comprehensive home care system offered by Caretenders. Featured are skilled and private duty home nursing services, home infusion services, and respiratory therapy and home medical equipment. Caretenders is Kentucky's largest home care provider.

**CARITAS Health Services #30**

1850 Bluegrass Ave  
Louisville, KY 40215  
(502) 361-6659

**Charter Ridge Behavioral Health System #34**

3050 Rio Dosa Drive  
Lexington, KY 40509  
(606) 268-6448

**Clayton L. Scroggins Associates, Inc #31**

200 Northland Blvd  
Cincinnati, OH 45246  
(513) 771-7070

Scroggins Associates brings to your practice Management Consulting expertise gained not only from doing in-depth consultations for hundreds of

doctors each year, but also from working with our continuing client base. Let us help you stay competitive in today's changing environment.

**Coastal Physician Services of the Midwest, Inc #65**

965 Ridgelake Blvd, Suite 305  
Memphis, TN 38120  
(901) 767-1301 or 1-800-777-1301

Coastal Physician Services, Inc, provides clinical contract management services. Offices are located near client hospitals to provide practice management teams for effective physician recruiting, credentialing, and scheduling. Related companies procure malpractice insurance, provide risk management/quality assurance consultation, and a variety of financial arrangements. Permanent placement opportunities are also available.

**Columbia Healthcare Network #36**

2200 Warrington Way, Suite 245  
Louisville, KY 40222  
(502) 327-5616

**Dawson-Weber Medical #66**

2100 Gardiner Lane, Ste 216A  
Louisville, KY 40205  
(502) 451-6272

Distributor for Hemocue Hemoglobin, Glucose and FSR. Hemocue is the ONLY manufacturer of a CLIA WAIVED Hemoglobin instrument and CLIA WAIVED Glucose instrument for diagnosing diabetes, not just screening. See us for appropriate CPT Codes.

Breathalyzer Breath Alcohol testing as required by D.O.T. for physicals as of Jan 1, 1995. Most primary office-based diagnostic instruments also available.

**Division of Disability Determinations #87**

Athletic Drive, 1st City Complex  
(mailing address: PO Box 1000)  
Frankfort, KY 40602  
(502) 564-8050, ext 4024

Obtaining good medical evidence and maintaining an adequate panel of consulting physicians is vital to the functioning of the social security disability program.

Representatives of the Kentucky Division of Disability Determinations Services (DDS) exhibit at professional medical conventions at local and state levels to promote understanding of the medical needs of the disability program. Thorough understanding, the medical community, and DDS can work together to serve the needs of Kentucky's disabled.

**Dodson Group #7**

9201 State Line  
Kansas City, MO 64114  
(800) 825-3760

Information regarding Dividend Program for Workers' Compensation Insurance.

**EHOB, Inc #61**

8395 Keystone Crossing, Suite 101  
Indianapolis, IN 46240  
(317) 251-8785

Air inflated decubitus prevention products. Our latest mattress overlay, the Expansion Control WAFFLE® Mattress, is patented, feature rich, and is as effective as the legendary original WAFFLE Mattress in pressure ulcer management. The Aperture-Occluded Grid Complex is a pattern of air passages and perimeter seals providing maximum level of pressure by maintaining the volume of air needed to support the patient. We will also show our popular Foot WAFFLE Heel Cushion.

**Eli Lilly and Company #109**

4350 Brownsboro Rd, Suite 110  
Louisville, KY 40207  
(502) 893-4518

**Floyd Memorial Hospital & Health Services #14**

1850 State Street  
New Albany, IN 47150  
(812) 949-5572  
1-800-423-1513

As the largest acute care facility in southern Indiana, Floyd Memorial Hospital & Health Services (FMHHS) is rated one of the top performing hospitals in the nation. With a service area of 250,000, FMHHS provides the most advanced technology available today



along with immediate expert consultations in more than 29 specialties. Our Level II Trauma Center is staffed by BC emergency physicians with 24-hour coverage. Floyd County is a diverse community offering charm and security for its 65,000 citizens while bordering the major metropolitan area surrounding Louisville. Stop by our booth to discuss practice opportunities in Floyd County, Indiana.

## **Fujisawa USA, Inc #76**

Three Parkway North  
Deerfield, IL 60015  
(708) 317-8880

Fujisawa USA, Inc, offers the latest drug delivery systems, cardiovasculars, micronutrients, HIV related medications, and anti-infectives, all designed to meet your changing needs.

## **Glaxo/Wellcome #17**

Five Moore Drive  
Research Triangle Pk, NC 27709  
(800) 5 GLAXO5

## **Greentree Applied Systems, Inc #5**

157 Prosperous Place  
Lexington, KY 40509  
(606) 253-2959

The Medistar-90 computer system was designed in Kentucky in 1990 specifically for Kentucky medical practices. We provide electronic claims submission directly to Medicare, Medicaid and Blue Shield without a per claim fee. Medicare electronic EOB, printed refund checks and prescription forms, optional clearing house, support for 3,600 insurance companies, multiple equipment platforms, HMO support, fast patient lookup and data entry, custom modifications, appointment scheduling, telephone collections and a bad debt subsystem are a few of our outstanding features. World class training and support are provided from Lexington.

## **Grogan's Healthcare Supply Inc #64**

1016 S Broadway  
Lexington, KY 40504  
(606) 254-6661

Join us in Grogan's booth for a look

at in-office lab equipment and surgical instruments.

## **Health Care Partners #32**

10500 Bluegrass Parkway  
Louisville, KY 40299  
(502) 499-9099

## **Hoechst-Roussel Pharmaceuticals Inc #82**

Route 202-206, PO Box 2500  
Somerville, NJ 08876-1258  
(908) 719-5824

Hoechst-Roussel Pharmaceuticals Incorporated cordially invites you to visit our exhibit where our outstanding sales representatives will welcome the opportunity to share information with you on Trental® (pentoxifylline) and Alta-ce® (ramipril).

## **Humana Health Care Plans #66**

PO Box 740023  
Louisville, KY 40201-7423  
(502) 580-5089

Humana Health Care Plans of Kentucky offers physician opportunities in Louisville, Lexington, Richmond, and Frankfort. Humana is looking for Internal Medicine, Family Practice and Pediatric practitioners who would enjoy practicing good medicine in one of 11 completely staffed and equipped offices. Physicians can "hit the ground running" and care for their patients without the headaches of administration when they work with one of the most progressive HMO providers in the nation.

## **Integrated Medical Systems, Inc (IMS) #116**

101 S 5th Street, Ste 2450  
Louisville, KY 40202  
(502) 562-0034

Since 1985, Integrated Medical Systems, Inc, has been applying communication and information technology for healthcare communities to more easily and efficiently exchange clinical, administrative and financial information.

IMS MEDACOM Networks are growing rapidly in communities across the United States. A MEDACOM Network links sponsoring healthcare organizations with physicians and other entities,

enabling participants to communicate with each other in a variety of ways. The advanced, automated MEDACOM Network speeds diagnosis, improves patient care, simplifies physicians' practices, increases efficiency and reduces costs.

## **Jewish Hospital HealthCare Services #28**

217 E Chestnut Street  
Louisville, KY 40202  
(502) 581-0907

In support of Jewish Hospital Health-Care Services' network physicians, the Physician/Hospital Development Department offers a comprehensive program to assist the private practice physician in building a practice and managing it effectively. Strategic planning resources are available to enhance the physician's service to the community.

## **KY Air National Guard #33**

1019 Old Grade Lane  
Louisville, KY 40213-2623  
(502) 364-9424

The Kentucky Air National Guard is a reserve component of the Air Force. It offers physicians and other medical professionals the opportunity to serve their state and nation in a unique way. Many doctors train to be flight surgeons which gives you the chance to fly, something no other part time job can offer. You also receive good pay, benefits, retirement, and other valuable training that will enhance your career now and in the future.

## **Kentucky Army National Guard Medical Recruiting #78**

Boone National Guard Center  
Frankfort, KY 40601-6168  
(502) 564-8575 or 1-800-372-7601 ext 575

Today, the mission of the Army National Guard is a dual one, state and federal. It offers physicians and other medical professionals the opportunity to serve their state and nation in a unique way. Many doctors train to be flight surgeons, battalion surgeons, general medical officers and other specialties, which

provides the opportunities that no other part-time career can. You also receive good pay, benefits, retirement, and other valuable training that will enhance your career. The Kentucky Army National Guard Recruiting Team will be available to answer any questions and give out literature. Stop in and see us or feel free to call us at (502) 564-8575 or 1-800-372-7601 ext 575.

**Kentucky Eagle Energy Co** #80  
530 W Main Street  
Louisville, KY 40202  
(502) 585-3800

**Kentucky Hospital Insurance Agency** #91  
1302 Clear Spring Trace  
Louisville, KY 40223  
(502) 426-6220

Kentucky Hospital Insurance Agency provides a full range of Property and Casualty and Life and Health insurance products and services to health care providers, including Kentucky Hospital Service Corporation's three Trusts: Kentucky Hospital Association Trust (KHAT) for professional liability; Compensation Hospital Association Trust (CHAT) for workers' compensation; and Kentucky Hospital Employee Health Benefit Trust (KHEHBT) dba TrustCare or health benefits.

**Kentucky Medical Insurance Company/ KMA Insurance Agency, Inc/ United Leasing, Inc** #79  
303 North Hurstbourne Parkway  
Louisville, KY 40222-5143  
(502) 339-5736

Established by the Kentucky Medical Association (KMA) during the insurance crisis of the mid-70s to give physicians more control over their own destiny. Our directive from the KMA was simple: provide adequate prices, maintain financial strength, and don't bail out when times are tough. United Leasing can provide medical equipment, office equipment and vehicles at affordable rates. Services available: Professional Liability, Leasing, KMIC Retirement

Trust, KMA Agency, Hospital Division.  
Service area: All of Kentucky.

**Kentucky Medical Review Organization** #50  
9502 Williamsburg Plaza, Ste 102  
Louisville, KY 40222  
(502) 339-7442

**Kentucky Organ Donor Affiliates** #44  
305 W Broadway Ste 316  
Louisville, KY 40202  
(502) 581-9511

**Kentucky Telco Federal Credit Union** #86  
3740 Bardstown Road  
Louisville, KY 40218  
(502) 459-3000

The KMA Credit Union expands your benefit package for your staff without adding cost! Kentucky Telco is a federal credit union with service centers located in Louisville, Lexington, Frankfort, and Owensboro, all delivering the finest in financial services: federally insured savings plans, low cost loans, Visa and MasterCard with no annual fee, MAC ATM service, 24 hour telephone response, and much more. Kentucky Telco is proud to be the only financial institution endorsed by the Kentucky Medical Association.

**Key Pharmaceuticals** #113  
2000 Galloping Hill Rd  
Kenilworth, NJ 07033  
(908) 298-4000

Exhibiting Key Pharmaceuticals line of cardiovascular and respiratory medications. The two newest additions include IMDUR, a once a day oral extended release formulation of isosorbide mononitrate in a new 120 mg strength tablet and Claritin D, an antihistamine decongestant for the relief of nasal and non-nasal symptoms of seasonal allergic rhinitis with congestion.

**Leake Pharmacy** #24  
220 S Third St  
Danville, KY 40422  
(606) 236-4464

**Lippincott-Raven Publishers** #8  
1145 Middleport Dr  
Columbus OH 43235  
(614) 326-1350

**Marion Merrell Dow, Inc** #39  
PO Box 9627  
Kansas City, MO  
(816) 966-5187

**Mark Kidd Studio** #53  
125 Clay Ave  
Lexington, KY 40502  
(606) 254-1095

**Masterpiece Medical** #92  
455 Wards Corner Rd  
Loveland, OH 45140  
(513) 831-6647

Masterpiece Medical has the most complete, comprehensive software system available for clinical and business management for physicians and payers alike. Masterpiece is a system designed to manage documentation in every physician-patient interaction. The system includes: electronic medical records, phone contact log, clinical outcomes measurement, health questionnaires, cost analysis, patient informed consent word processing, ICD-9, CPT, drug files, password protection and more. The clinical and financial outcomes from the system can be used for the evaluation of profit or loss, reimbursements, and research results.

**Mead Johnson, The Nutrition Company** #42  
2400 W Lloyd Expressway  
Evansville, IN 47721  
(812) 429-7343

We cordially invite you to visit our exhibit to meet our representatives who welcome the opportunity to discuss products and services of interest to you. Featured will be: Enfamil®, Lactofree®, Next Step®, Nutramigen®, ProSobee®, Sustacal®, Temptra®.

**Medical Management Resources, Inc.** #54  
10180 Linn Station Rd, 2C  
Louisville, KY 40023  
(502) 423-6777



**The Medical Protective Company #70**  
5814 Reed Road  
Fort Wayne, IN 46835  
(219) 486-0473

**Mediplex Rehab-Bowling Green #87**  
1300 Campbell Lane  
Bowling Green, KY 42104  
(502) 782-6900  
Comprehensive inpatient and outpatient medical rehabilitation treating patients recovering from brain injury, spinal cord injury, orthopedic surgeries, strokes, arthritis, pain, neuromuscular and pulmonary disorders.

**Merck & Co Inc #102**  
200 Stirrup Circle  
Nicholasville, KY 40356  
(606) 885-8130

**Merck Vaccine Division #111**  
5432 Magnolia Grove  
Memphis, TN 38120  
(901) 763-3926  
The purpose of the Merck Vaccine Division is to improve health and quality of life worldwide by guiding the research, development, and manufacturing, and by directing the marketing of, products and related services that prevent life-threatening or disabling illnesses and conditions through immunologic mechanisms.

**(Miles) Bayer Corporation-Pharmaceuticals #19**  
19500 Victor Pkwy #525  
Livonia, MI 48152  
(313) 591-6900  
Cipro Tablets; Cipro IV; Adalat CC; Trasylol; Prolastin.

**Mutual of New York #38**  
PO Box 3070  
Lexington, KY 40595  
(606) 231-7575  
We are a mutual company dealing in insurance and financial investment products.

**Norton Psychiatric Clinic #59**  
200 E Chestnut St  
Louisville, KY 40202  
(502) 629-8850

**National Health Laboratories Inc #67**  
4500 Conaem Dr  
Louisville, KY 40213  
(502) 456-4700  
Our Mission: To Deliver Information And Quality Results In A Timely Fashion. To Aid In The Diagnosis Of Disease, And To Assist In The Prevention Of Suffering And The Avoidance Of Pain.

**Olympus America, Inc #108**  
2 Corporate Center Drive  
Melville, New York 11747  
(516) 844-5000  
Olympus offers a full line of endoscopy products for all medical specialties. Features are complete video endoscopy systems for both GI (Evis 100) and pulmonary (Evis 200) applications including image documentation and management systems (Imagemanager). Olympus also supplies a full range of accessory and ancillary devices to meet all your endoscopy requirements.

**Pfizer Labs #23**  
14402 Willow Grove Circle  
Louisville, KY 40245  
(502) 254-1170

**Pharmacia Adria #89**  
PO Box 16529  
Columbus, OH 43216-6529  
(800) 729-2902

**Physician Sales and Service #37**  
1915 Production Dr  
Louisville, KY 40299  
(502) 495-6321

**The PIE Mutual Insurance Company #77**  
9300 Shelbyville Road, Suite 1001  
Louisville, KY 40222-5183  
(502) 339-7431; WATS #800-228-7431  
The PIE Mutual Insurance Company of Cleveland, Ohio offers Kentucky physicians the advantages of an insurance program that has made it the leading professional liability carrier in Ohio. Owned and controlled by policyholders, the PIE is a non-profit company whose innovative program features claims handling by a specialty law firm, physician participation in all areas of

operations including peer review of all applicants, and rate stability that rewards loss-free physicians with scheduled premium reductions.

**Pikeville Methodist Hospital #35**  
911 South Bypass  
Pikeville, KY 41501

**Proctor & Gamble Pharmaceuticals #93**  
11520 Reed Hartman Highway  
Cincinnati, OH 45241  
(512) 626-6523

**Ransdell Surgical Inc #73**  
752 Barret Ave  
Louisville, KY 40204  
(502) 584-6311

**Rexall Showcase International #88**  
1520 Hawkshead Ln  
Louisville, KY 40220  
(502) 499-9909  
This exhibit features the newest and fastest growing division of Rexall; Rexall Showcase International RSI distributes nonprescription preventative health care products. These products address, in a proactive fashion, such wide-ranging health issues as cardiovascular health, stabilization of blood sugars, skin therapy and nutritional supplementation.

**Roerig Division of Pfizer #22**  
914 Bridgecreek Rd  
Louisville, KY 40245  
(502) 254-5871

**Schering Oncology/Biotech #101**  
2000 Galloping Hill Road  
Kenilworth, New Jersey 07033  
(908) 298-4000  
Pharmaceutical and Biotech products for treatment of chronic viral hepatitis B & C and for various malignancies.

**G. D. Searle & Co #112**  
Box 5110 Old Orchard Rd  
Skokie, IL 60680  
(708) 470-6800

**SmithKline Beecham Clinical Labs #83**

2277 Charleston Drive  
Lexington, KY 40505  
(606) 299-3866  
Clinical Laboratory.

**SmithKline Beecham Pharmaceuticals #29**

4445 Lake Forest Drive  
Suite #490  
Cincinnati, OH 45242  
(513) 733-5354

**Southeastern Data Systems, Inc #6**

Corporate Plaza, Suite 650  
Lexington, KY 40503  
(606) 223-6382  
Complete turnkey hardware and software Medical Billing, Commercial Electronic Billing, Scheduling, Medical Records, and Financial Accounting Systems.

**Southeastern Group, Inc #69**

9901 Linn Station Rd  
Louisville, KY 40223  
(502) 423-2298

**Spectrum Healthcare Services #25**

PO Box 419052  
St. Louis, MO 63141  
(800) 325-3982  
Spectrum Healthcare Services is a clinical contract management company which provides healthcare and administrative management services to hospitals, physicians, clinics, managed care programs, business, government entities and insurers. Additionally, it operates a correctional healthcare division which provides comprehensive health, dental and mental health services on a capitated basis to correctional facilities nationwide.

**St. Joseph Hospital #41**

One St. Joseph Drive  
Lexington, KY 40504  
(606) 278-3436

**3M Pharmaceuticals #62**

3M Center, Bldg 275-3W-01  
St. Paul, MN 55144-1000  
(612) 736-4920  
3M Pharmaceuticals invites you to visit our booth, where our sales representa-

tives will be happy to discuss MAXAIR™ Autohaler™ (pirbuterol acetate inhalation aerosol) and our orphenadrine products, Norflex™ B.I.D. (orphenadrine citrate) extended-release Tablets, and Norgesic™ Forte (orphenadrine citrate 50 mg; aspirin, 770 mg; caffeine, 60 mg).

**US Air Force Health Professionals Recruiting #117**

2515 Perimeter Place Dr  
Nashville, TN 37214-3671  
(615) 889-0723  
We are not a Technical Exhibit but an information exhibit for recruiting Air Force Health Professionals.

**University of Kentucky Chandler Medical Center #51**

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Thursday, September 21, 1995

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General Sessions Area - Lexington Center

The KMA designates this CME activity as meeting the criteria for 2 credit hours in Category 1 of the Physician's Recognition Award of the AMA.

The Kentucky Cabinet for Human Resources has approved "HIV Update for Physicians" as meeting the requirements for KRS 214.610/615. Approval #0797-433-S

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Three types of presentations are welcome:

- Poster presentations: written presentations of data-based research
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- Workshops: Training or instructional presentations designed to improve the skills and knowledge of persons working in the physician health field

Abstracts for all presentations must be submitted on the abstract submission form which is available from: American Medical Association, Physician Health Program, Attn. E. Tejcek, 515 North State Street, Chicago, IL 60610.

All presenters must register for the conference and will pay the AMA member rate. Presenters will be responsible for their own expenses.

Questions or requests for abstract submission forms may be sent to the address above or directed to 312 464-5066 or faxed to 312 464-5841.

**Deadline for  
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## William H. Mitchell, MD Nominated for KMA President-Elect

**W**illiam H. Mitchell, MD, has been nominated by the Madison County Medical Society for the office of President-Elect of the Kentucky Medical Association.

A surgeon practicing in Richmond, Dr Mitchell has been diligent and dedicated in his contributions to organized medicine. He served KMA as Delegate and as 11th District Alternate Trustee from 1981 to 1987, and as 11th District Trustee from 1988 to 1993, when he was elected to his current position of Vice-President. Dr Mitchell also currently chairs the Pro Advisory Committee and is a member of the Physician Workforce and Professional Liability Insurance Committees.

Other professional memberships include the Kentucky and American Societies of Gastrointestinal Endoscopy, American College of Surgeons, and Johns Hopkins Medical and Surgical Association. During 1992-93, Dr Mitchell served simultaneously as President of the Kentucky Chapter American College of Surgeons, Hiram C. Polk Surgical Society, and the Madison County Medical Society.

A native of Salisbury, Maryland, Dr Mitchell received an undergraduate degree from Johns Hopkins University in 1964 and a medical degree from the University of Kentucky in 1970. Following completion of an internship and residency/fellowship at Johns Hopkins Hospital in 1970-72 and a residency in general surgery at the University of Louisville in 1972-75, Dr Mitchell served as a Lieutenant Commander in the US Navy from 1975 to 1977. During that period he served as a ship's surgeon on the USS John F. Kennedy and as attending surgeon at the Portsmouth Naval Hospital in Virginia.



In 1977, Dr Mitchell began a private surgical practice in Richmond. He has privileges at Pattie A. Clay Hospital, where he has served as Chief of Staff. He also has privileges at Marcum Wallace Memorial Hospital in Irvine, Berea Hospital in Berea, and serves on the clinical faculty in surgery at both the University of Kentucky and the University of Louisville.

Dr Mitchell and his wife Winifred have three children and reside in Richmond.





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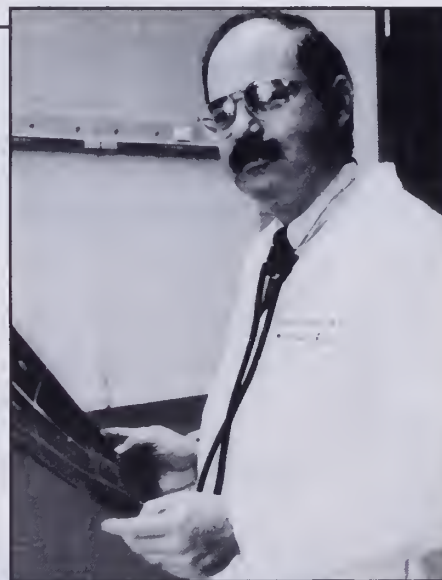
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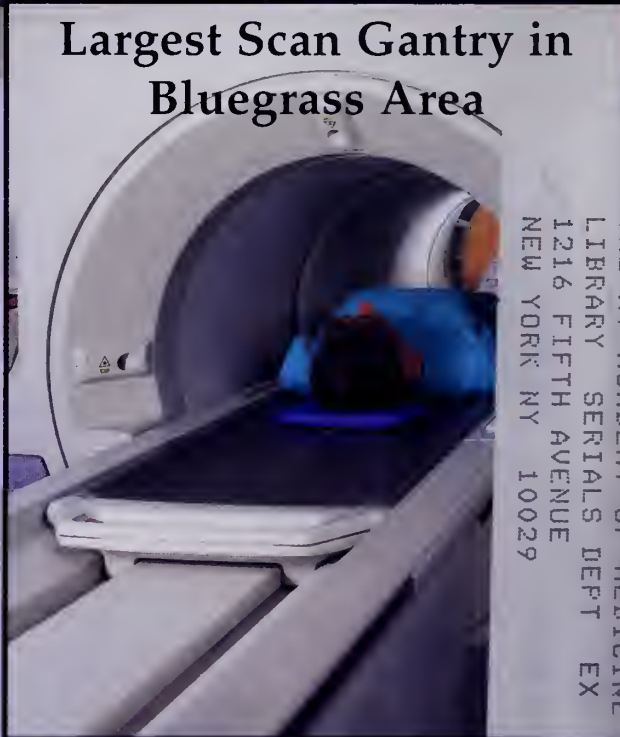
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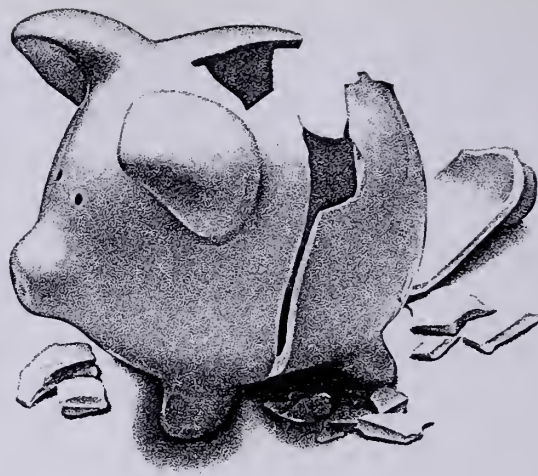


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SEPTEMBER 1995  
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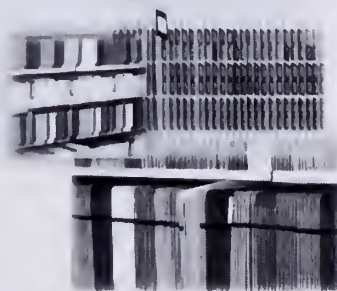


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VOLUME 93, NUMBER 9

SEPTEMBER 1995

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**COVER:** A Louisville surgeon discusses the management of fecal incontinence in an article beginning on page 398. Artwork by Stephen Sebree of Louisville. (With permission to reprint from Wayne B. Tuckson, MD).

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Robert R. Goodin, MD

## Ethical Dilemmas in a Changing Health Care System

I promised one year ago when I assumed the presidency, to promote the theme "Pride in our Profession." I can assure you that as I have had the privilege to interact with physicians throughout our state, even in these stressful times, my pride has grown enormously. To the countless physicians who have given so generously of your time and energy to the great benefit of our patients, I say a heartfelt *Thanks*. You and our elected leadership are responding in the fine fashion our profession deserves.

We face many challenges these next few years as our health care delivery system goes through a transition period. Not only must we deal effectively with market-driven health care delivery, but also respond in Kentucky to one of the most expansive, punitive to health care providers, and potentially damaging health system reforms in America. Despite these reforms, I honestly believe that it is the impact of managed care growth on how we care for our patients that will dominate our lives these next several years. From a purely professional standpoint, our greatest challenge will be to maintain our high ethical standards as we work in a system that focuses on cost and not on quality and one that rewards less care and

seeks to ration or deny care. On the one hand, we are being asked to deliver the best treatment available while on the other hand, we are expected to be more efficient, spend less time with patients, and restrain access to beneficial care simply because it is expensive.

Several ethical dilemmas present themselves:

- How much health care is enough?
- Is health care a Right?
- What is a fair minimum benefit package?  
Who decides?
- Who decides quality standards?
- How do we provide access for all?
- Who's responsible for the uninsured?
- Should all patients have full choice of benefits?  
Physicians? Specialists?
- Will physicians be forced to ration care at the bedside?
- How much end-of-life care is appropriate?
- Will Managed Care handicap medical research and new advances?
- Will medical education standards be compromised?
- Are Managed Care systems being held accountable?

From an ethical standpoint, do we really need lengthy deliberation and debate in order to answer most

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*"We cannot consider ourselves true professionals if we allow our own self interest to come between us and our obligation to serve as the patient's advocate."*

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of these questions? Just because our health care delivery system is changing, does it also hold that professionalism and ethical standards are open to compromise? Let's be honest, the physician-patient relationship has always involved a degree of conflict of interest between our need to earn a living and a decision to provide the best care to our patients. It will indeed be a sad state of affairs if we do not choose the ethically highroad, but instead allow regulations and laws to become necessary to dictate ethical behavior for us. As we face the myriad questions and many more not even raised yet, I suggest to you that our answer must meet the same uncompromising and most important ethical test of all — does it meet the needs and best interest of the patient? We cannot consider ourselves true

professionals if we allow our own self interest to come between us and our obligation to serve as the patient's advocate. One can discuss and debate limitless facets of the questions raised from a pragmatic standpoint, but the ethical answer is the same — if it is best for the patient, then it is the right thing to do. Our patients must continue to know that our concern for them will override any financial consideration. Our patients may not know how much we know, but they certainly know how much we care.

God blessed physicians with special talents and society has truly granted us the great privilege and honor to practice medicine. The Bible verse "from those to whom much is given, much is expected" rings especially true for us physicians. As we face these challenging times, let

us avoid becoming "money-grubbers," but instead practice our art with altruism and commitment to the core values that our proud and noble profession deserves. Our patients and our profession deserve no less.

I cannot conclude my year without offering my thanks and sincere gratitude to the marvelous staff of the Kentucky Medical Association led by Mr Bobby Cox. Suffice it to say, these dedicated people are the heart and soul of our Kentucky Medical Association. Without them, we simply would not exist.

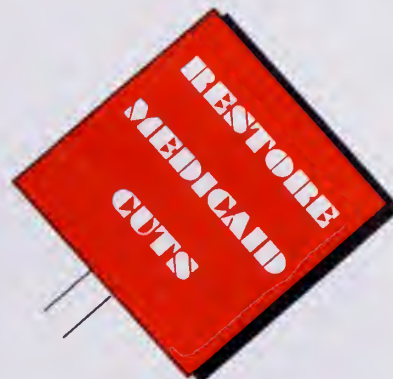
I also wish to thank all Kentucky Physicians for granting me the honor and privilege to serve as your President.

**Robert R. Goodin, MD**  
KMA President

# MONITORING MEDICINE



## KMA PRESENTS PRE-LEGISLATIVE SEMINARS FOR PHYSICIANS AND SPOUSES



DISTRICT	DATE	LOCATION
1st	October 25	Paducah
2nd	October 24	Owensboro
3rd	October 30	Madisonville
4th	October 5	Elizabethtown
5th	October 16	Louisville
6th	October 23	Bowling Green
7th	October 9	Frankfort
8th	September 28	Florence
9th	October 18	Cynthiana
10th	October 10	Lexington
11th	October 11	Richmond
12th	October 31	Danville
13th	October 19	Ashland
14th	October 17	Pikeville
15th	October 12	Corbin

NOTE: Each district member will receive individual mailing with time, meeting site, etc.

The KMA Public Education Committee, Committee on State Legislative Activities, and KEMPAC present special Pre-legislative Conferences designed for physicians and spouses. Topics include:

- Disseminating information and strategy to support effective lobbying
- Defining and prioritizing medicine's 1996 legislative goals
- Political grassroots--the 1996 election cycle and beyond
- Lobbying--what to say--how to say it--when to say it

### HB 250 REPEAL OR AMEND

- \* Discount Option Program
- \* Free Medical Records
- \* Practice Parameters



Anal Injury

Birth Trauma

Iatrogenic

Neuropathy

Diarrhea





# Management of Fecal Incontinence

Wayne B. Tuckson, MD

The ability to control rectal evacuation until an appropriate or socially acceptable time is dependent upon stool characteristics and anorectal function. The loss of this control — incontinence — may lead to the loss of self esteem and social isolation. The incidence of incontinence is greater in women than men and increases with advancing age. Ten to 17% of nursing home patients and 13% to 47% of hospitalized elderly patients are also incontinent of feces.<sup>1</sup>

Incontinence results from multiple factors (Table 1), including inundation of normal sphincters by large volumes of watery stool, anal sphincter disruption, and an inability for the patient to recognize and respond to the urge to defecate. Fecal impaction is the most common cause of incontinence in nursing home patients,<sup>2</sup> but sphincter injury as a complication of vaginal delivery is the most common cause overall (Table 2).<sup>1</sup> During vaginal delivery, the anal sphincters are directly and indirectly at risk for injury. Sphincter integrity may be disrupted following perineal laceration or function compromised as a result of disruption of innervation.<sup>3,5</sup>

## Anatomy

The anal canal is 4 cm in length and extends from the anal verge to the anorectal junction, which is at the level of the puborectalis muscle. Sensory innervation is supplied by branches from the pudendal nerve. This innervation enables recognition of the passage of rectal contents into the anal canal and determination as to whether these contents are solid, liquid, or gas.<sup>6</sup>

An increase in rectal volume has minimal impact on intrarectal pressure. This receptive relaxation makes the rectum an ideal reservoir for waste. A normal rectum can hold from 300 to 350 mL of fluid with little change in pressure. When this volume is exceeded, intrarectal pressure increases and evacuation is initiated. However, when inflamed, rectal contraction is initiated at smaller volumes.

Perception of rectal distention is mediated by stretch receptors located in the pelvic floor muscles.<sup>7</sup> Rectal distention also stimulates nerve endings of the enteric nervous system located within the rectal wall, causing internal anal sphincter relaxation. This relaxation permits passage of rectal contents into the anal canal.

The muscles involved in continence are the internal anal sphincter (IAS), the external anal sphincter (EAS), and the puborectalis (PR) muscle. These muscles form a barrier to rectal evacuation.

The IAS is the terminal portion of the circular muscle of the rectum and is composed of smooth muscle fibers. It is innervated by both the autonomic and enteric nervous systems. Sympathetic stimulation causes contraction, and inhibitory impulses initiated by rectal distention are transmitted by the enteric nervous system and produce IAS relaxation. The IAS is normally contracted and accounts for 85% of the resting pressure in the anal canal.<sup>8</sup>

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Table 1. Factors Affecting Continence

• Intestinal	• Anal	• Rectal
— Transit time	— Tone	— Capacity
— Absorption	— Sphincter Function	— Compliance
— Inflammation	— Innervation	— Sensation
	— Sensation	

Table 2. Causes of Fecal Incontinence

• Obstetrical Injury	• Peripheral Neuropathies
• Idiopathic	• Spinal Deformities
• Iatrogenic Surgical Injury	• Diabetes
• Congenital Anomalies	• Sarcoidosis
• Prolapse	• Radiation Injury
• Accident/Trauma	• Laxative Abuse
• Central Nervous System Disorders	• Fecal Impaction



## Management of Fecal Incontinence

The EAS is composed of skeletal muscle fibers and receives motor innervation from the inferior hemorrhoidal nerve. Contraction of the EAS is voluntary and increases anal canal pressure.

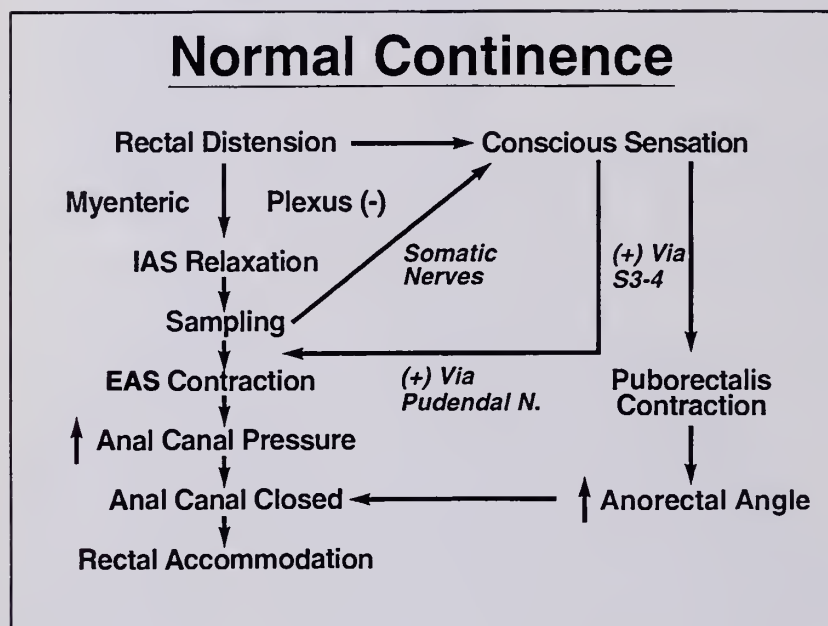


Fig 1 — Mechanism of normal continence. Abbreviations: IAS, internal anal sphincter; EAS, external anal sphincter; S3-4, sacral roots S3 and S4; N., nerve.

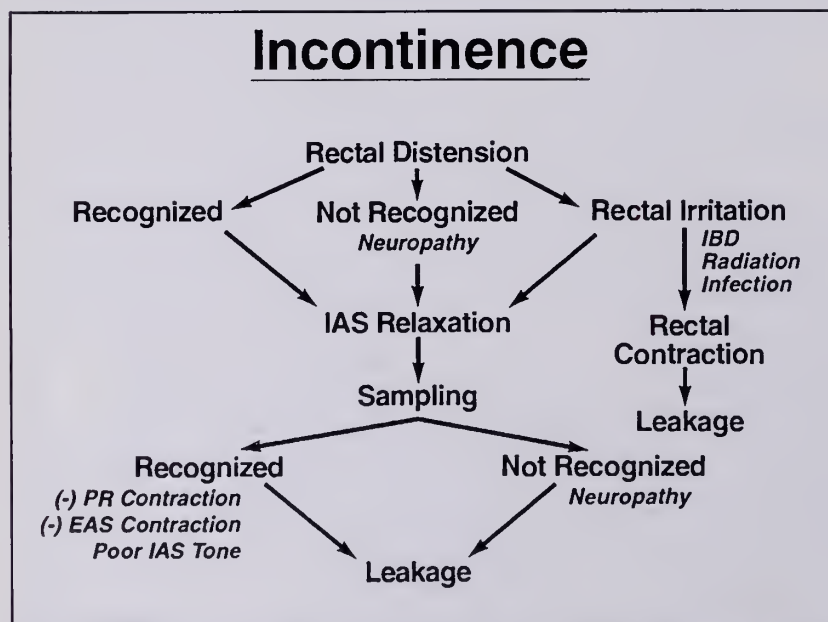


Fig 2 — Pathology of incontinence. Abbreviations: IBD, inflammatory bowel disease; IAS, internal anal sphincter; PR, puborectalis muscle; EAS, external anal sphincter.

Most EAS fibers fatigue after 60 to 90 seconds of contraction. Some EAS fibers, however, are capable of maintaining prolonged contraction. These fibers account for 15% of the resting anal canal pressure.<sup>8</sup>

The PR is composed of skeletal muscle fibers and forms a sling at the level of the anorectal junction. The course of the PR pulls the anorectal junction anteriorly creating an angle. Voluntary contraction accentuates the anorectal angle, thus obstructing the passage of rectal contents.<sup>9</sup> The motor innervation to the PR is from branches of sacral roots S3 and S4. Similar to the EAS, some PR fibers are capable of prolonged contraction without fatiguing. These are the fibers that maintain the anorectal angle at rest.

### Pathophysiology

Normal defecation is a consequence of involuntary and voluntary responses to rectal distention. Rectal distention initiates IAS relaxation, which allows passage of the rectal contents into the anal canal where they are sampled. If the timing and situation are appropriate, both the PR and EAS are relaxed and the rectum is evacuated. Should the situation be inappropriate for evacuation, then the PR and EAS are contracted, thus closing the anal canal (Fig 1). Incontinence results from either (1) a failure to perceive or respond to rectal distention and sampling, (2) a failure of PR or EAS contraction, (3) IAS dysfunction, (4) loss of rectal compliance, or (5) inundation of intact sphincters by large volumes of watery stool (Fig 2).

### Diagnosis

Proper treatment begins with identifying the cause of incontinence, determining the frequency of episodes, and evaluating the impact on the patient. There are many adjunctive tests available to evaluate anorectal function, but no single test is superior to a thorough history and physical examination.<sup>10,11</sup> A history should include obstetrical history, bowel habits, medication use, and prior surgery (Table 3). The use of absorbent pads, adult diapers, and the timing and frequency of incontinent incidents should also be noted. A diary is an effective means to identify causative factors such as diet and medications and to accurately determine the number of incidents.

The anal examination may be performed

**Table 3.** History

• Obstetrical	• Central Nervous System
— Parity	— Spinal cord disorders
— Length of labor	— Peripheral neuropathy
— Episiotomies/ Perineal tears	• Cerebral Disorders
• Surgery	— Congenital
— Fistulotomy	— Imperforate anus
— Sphincterotomy	• Trauma
— Bowel resections	• Anal Intercourse
— Hemorrhoidectomy	• Prolapse
• Medications	• Inflammatory Bowel Disease
— Laxative abuse	• Diabetes

with the patient in either the left lateral decubitus, knee chest, or dorsal lithotomy position. The inspection and digital examination should occur while the anus is at rest, during voluntary contraction, and during attempted defecation. At rest, the anus is closed and has an oblong shape (Fig 3). The presence of scars, deformities, and anal position are noted (Fig 4 and Table 4). Atrophy of the EAS or IAS may be evident if the anus appears flat. If the IAS is nonfunctional, the anus is patulous (Fig 5). Voluntary contraction produces retraction and tightening of the anus. Straining to defecate may unmask a prolapse or evidence of excessive perineal descent.

Circumferential palpation of the anus identifies sphincter deficiencies and disruptions. Fecal impaction and anal masses are apparent on insertion of the examining digit. IAS tone is reflected by pressure exerted on the examining finger in the anal canal at rest and EAS tone by changes in pressure during voluntary contractions. PR function is determined by noting the force with which the finger is pulled anteriorly during contraction.

Proctosigmoidoscopy, colonoscopy, and barium enema examinations are all useful in excluding potential causes of incontinence such as inflammatory bowel disease, radiation proctitis, and acute colitic conditions. Patients with diarrhea should also have stool samples submitted for culture, ovum, and parasite examinations.

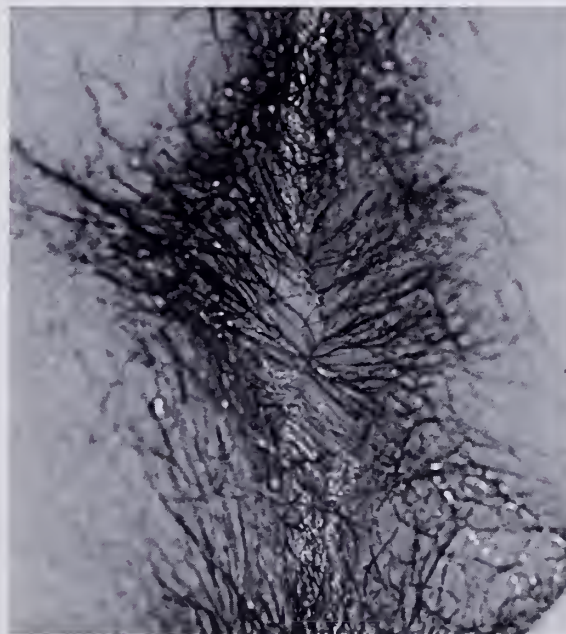
A more objective evaluation of anal sphincter function and integrity can be obtained by performing physiologic testing. These tests include anal manometry, anal electromyography, defecography, and endorectal ultrasonography (Table 5).

Anal manometry, using an intra-anal catheter,

measures anal canal pressures at rest and during voluntary contractions. Typical resting anal canal pressures are between 40 and 80 mmHg, and contraction increases anal canal pressures between 1.5 and 2 times the resting value. The functional length of the anal canal is reflected by the area of high pressure in the anal canal.

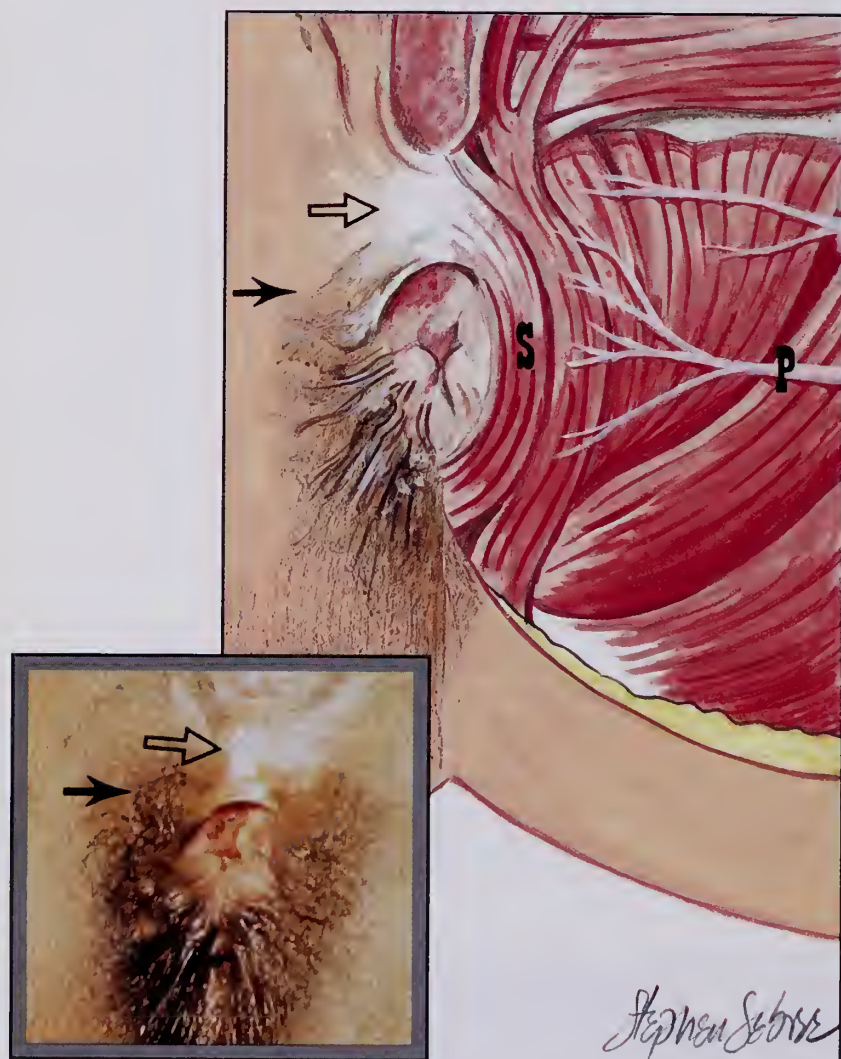
Anal electromyography measures EAS and PR electrical activity.<sup>12</sup> Sphincter contraction requires the recruitment of other motor units and is reflected by an increase in electrical activity that is higher than resting baseline levels. Failure to elicit an increase in activity during an attempt at contraction is indicative of either neuropathy or other nerve injury. Other uses for electromyography are documentation of prior nerve injury by identifying evidence of reinnervation with single fiber electromyography, mapping of sphincter muscle with concentric needle electrodes, and detection of pudendal neuropathy with prolonged pudendal nerve terminal motor latencies.

Endorectal ultrasonography has been effective in evaluating patients with traumatic fecal incontinence. The site of sphincter disruptions are visible, providing both confirmation of the trauma and a map to locate the sphincters.<sup>13</sup> This technique is tolerated better than needle electromyography and can be repeated as needed.<sup>14</sup>

**Fig 3 — Normal anus at rest.**



## Management of Fecal Incontinence



**Fig 4** — An illustration and photograph of the same patient with sphincter disruption following birth trauma. Open arrows show site of sphincter disruption, scar tissue, and loss of perineal body. Closed arrows show edge of intact sphincter. P, pudendal nerve; S, internal anal sphincter. Artwork by Stephen Sebree of Louisville.

Defecography, though of value in evaluating patients with outlet disorders, adds little to the evaluation of the incontinence.<sup>15</sup>

### Treatment

The treatment of fecal incontinence varies with the severity and etiology of incontinence and may either be operative or nonoperative. Patients with sphincter disruptions are best managed operatively, while those with nerve injuries are initially

**Table 4.** Physical Findings

• Potulous Anus	• Key Hole Deformity
• Excessive Perineal Descent	• Ectopic Anus
• Perineal Irritation	• Rectal Prolapse
• Anal Fistulae	• Sphincter Contraction
• Surgical Scars	• Anal Sensation
	• Proctitis/Colitis

managed nonoperatively. Nonoperative management includes dietary and pharmacological manipulation, bowel training, and biofeedback. Operative treatment includes sphincteroplasty, pelvic floor reconstruction, neosphincter creation, and stoma formation (Table 6).

**Nonoperative Management.** Initial management includes avoidance of foods such as dairy products, alcohol, and caffeine that may produce diarrhea. Furthermore, foods identified in the patient's diary that are associated with diarrhea and incontinence are also avoided.

If incontinence results from diarrhea, then management is directed towards controlling the diarrhea and treatment of the underlying disorder. Incontinence secondary to rectal inflammation such as radiation proctitis or idiopathic proctitis often responds to topical treatment with enemas containing either corticosteroids or 5-aminosalicylic acid. Bulking agents, when taken with minimal fluids, may absorb intestinal fluids and thicken loose stools. The resultant thicker stools are easier to control and continence may return or be improved. Unfortunately, the increase in gas production associated with many bulking agents may limit use because of an incontinence for flatus.

Constipating medications such as codeine, opioids, diphenoxylate hydrochloride and loperamide slow intestinal transit and facilitate absorption resulting in thicker stools and a smaller volume. Loperamide has the added benefit of increasing IAS tone and anal canal resting pressure.<sup>16,17</sup> This effect can be exploited to improve continence in patients with an intact, but weakened IAS.<sup>18</sup>

Bowel management programs attempt to regulate stool evacuation and minimize spontaneous defecations.<sup>18</sup> A successful program includes (1) a well balanced diet, including foods high in fiber; (2) meals taken at set times; (3) sitting on the commode 20 to 30 minutes after the morning meal; (4) stimulation of rectal evacuation with



Fig 5 — Patulous anus at rest. Note the gaping.

Table 5. Anorectal Physilogic Testing

- |                                  |   |
|----------------------------------|---|
| • Anal Monametry                 | • Electromyography                      |
| — Anal conal length              | — Matar unit recruitment                |
| — Anal canal resting pressure    | — Pudendal nerve terminal motor latency |
| — Anal canal squeeze pressure    | — Single fiber electromyography         |
| — Rectoanal inhibitory reflex    | • Defecography                          |
| • Rectal Manometry               | — Anorectal angle                       |
| — Recognition rectal distention  | • Endarectal ultrasananography          |
| — Volume initiating urge to void |   |
| — Maximum tolerated volume       |   |

Table 6. Treatment

- |                                |                       |
|--------------------------------|-----------------------|
| • Nonoperative                 | • Operative           |
| — Bowel Management             | — Sphincteroplasty    |
| — Phormacological Monipulation | — Sphincter Plication |
| — Dietary Monipulation         | — Neosphincter        |
| — Biofeedback                  | — Calectamy           |
| — Symptamotic Treatment        | — Stomo               |

either a suppository or an enema; and (5) abdominal massage to facilitate movement of stool through the colon.

With biofeedback, sphincter tone may be strengthened through exercising, and the patient learns to recognize events preceding defecation and techniques to defer defecation. The patient who is most likely to benefit from biofeedback is ambulatory, motivated, and capable of performing the biofeedback exercises. Improvement following biofeedback has been noted,<sup>19</sup> but reinforcement at regular intervals must be done to maintain the results.<sup>20</sup>

**Operative Treatment.** The goal of surgical therapy is to reestablish control of the passage of stool and gas. The surgical techniques include sphincteroplasty, creation of a barrier, neo-anal sphincter insertion, and stoma formation.

Preparation for surgery includes mechanical bowel preparation on the day prior to surgery with either a polyethylene glycol solution or Fleets phospho soda® and systemic antibiotics on the day of surgery. Preoperative oral antibiotics are optional. In the operating room a Betadine enema is administered, and the perineum, lower abdomen, medial aspect of the thighs, and the vagina are prepped.

The patient is placed in the dorsal lithotomy position for anterior sphincter repairs, anterior sphincter plications, neo-anal sphincters, and bar-

riers. Posterior anal repairs and plications are performed with the patient in the prone jackknife position.

Overlapping sphincteroplasty is preferable for patients with traumatic sphincter disruption. It is indicated when viable muscle is present, the innervation is intact, and sufficient length is available to overlap the ends. The goal of this procedure is to reconstitute sphincter integrity by overlapping the cut ends of the IAS and EAS. The basic surgical principles include: (1) do not excise the scar, because it is used to bolster the repair; (2) obtain adequate lateral mobilization of the sphincters; (3) avoid injury to the inferior rectal artery and nerve; (4) overlap the sphincters rather than attempt end to end approximation; and (5) tighten the anal canal to the size of the small finger. In the absence of nerve injury, up to 90% of patients who undergo overlapping sphincteroplasty have good functional results.<sup>21, 22</sup>

Anterior and posterior sphincter plications are indicated where the sphincters are weakened, but intact. The attempt is to lengthen the anal canal, tighten the anal canal, and reestablish the anorectal angle. The long-term results following sphincter plication alone are not encouraging.<sup>23-25</sup>

The Thiersch procedure creates a static barrier to rectal evacuation by wrapping a band of inert material around the anal canal. This band partially occludes the anus, inhibiting rectal evac-



## Management of Fecal Incontinence

uation. This approach is indicated for patients with sphincter loss or a neurogenic cause of incontinence. Unfortunately, the results are not good and patients may have difficulty with evacuation or experience erosion of the material used through the anus.

Gracilis muscle transposition is an operation that is being revisited. As originally described, the gracilis muscle was detached at the knee with care to preserve the neurovascular bundle. The muscle was then wrapped around the anal canal, and the tendon was sewn to the contralateral ischial tuberosity. The results following the original technique were not good.<sup>26</sup>

The gracilis muscle transposition has since been modified by incorporating electrical stimulation of the gracilis muscle. The electrical stimulation converts the native fast twitch skeletal fibers to slow twitch fibers capable of maintaining prolonged contraction without fatiguing.<sup>27</sup> This neosphincter has functions similar to a normal anal sphincter in that interruption of electrical current stops the contraction long enough to allow passage of gas and stool. Several studies have reported good results characterized by increases in anal canal pressure and an improvement in continence. Electrically stimulated gracilis transposition will likely become the preferred treatment for patients with incontinence secondary to loss of sphincter mass or neuropathy.

Colectomy is an option limited to patients whose incontinence is secondary to colonic disease. Colectomy with rectal preservation is indicated when the rectum is not involved. This preserves rectal reservoir function and has a superior functional result. Patients with rectal disease not responsive to medical management may benefit from proctectomy with coloanal anastomosis if the anal sphincter function is good. If both the colon and rectum are diseased, an ileal pouch anal anastomosis may be considered when the anal sphincter is functional.

Patients who have had unsuccessful sphincter repairs and who are not candidates for a neosphincter will require a stoma. A colostomy affords a measure of control and can facilitate return to normal activities. Occasionally, a temporary stoma is created at the time of sphincter repair to limit contamination and to give the sphincteroplasty site a chance to heal. Prior to creating a stoma, consultation with an enterostomal therapist is of great benefit for both patient support and choosing the optimum site for placement.

## Conclusions

The management of incontinent patients begins with the history and physical examination. The type of patient most likely to suffer incontinence are women with prior obstetrical injuries and the aged with fecal impaction.

Patients with diarrhea caused by medical conditions will benefit from symptomatic treatment and treatment directed towards the medical illness. In the patient with weak but intact sphincters, biofeedback can be beneficial. Most patients with sphincter disruption and intact innervation have marked improvement following overlapping sphincteroplasty while those with neurogenic fecal incontinence may benefit from neosphincter creation using an electrically stimulated gracilis muscle.

The incontinent patient is appreciative of the concern and grateful for treatment. Resumption of continence restores self esteem, lifts their sense of isolation, and returns the patient to normal social interaction.

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# Women Physicians

**W**omen now comprise close to 20% of all US physicians and more than 40% of all medical students. While the total number of male physicians in the US increased 65% between 1970 and 1990, the total number of women physicians increased almost 300%. AMA projects that by the year 2010, 30% of all physicians will be women.

In Kentucky, there are currently 1,300 women physicians either in practice or in residency training, representing 20% of all Kentucky physicians. While involvement in organized medicine is increasing among women physicians at the state and national levels, only 14% of KMA active members are women, while one-fourth of all nonmember physicians are women.

The Kentucky Medical Association and American Medical Association have designated September as Women in Medicine Month to recognize and celebrate the growing number and influence of women physicians in the profession and the community. Women physicians are bringing new perspectives to physician/patient relationships and health policy and research development. They are also leading change through their involvement in important public health initiatives and in helping the profession to address the need for professional/family balance within the medical education and training environment. In this special feature, KMA highlights just a few of the many women physicians who are MAKING A DIFFERENCE. . . .

# Leading Change

## GETTING INVOLVED IN PATIENT ADVOCACY

### WHO IS RESPONSIBLE?

**W**hat can I do about it? Am I my brother's (patient's) keeper? Why do I have to get involved? As physicians, I think we know the answers to every one of these questions if we search our hearts.

I became involved with domestic violence crime as a resident in family practice. While serving on KMA's Community and Rural Health Committee, I was appointed to chair a Subcommittee on Domestic Violence as a result of a resolution from some other concerned physicians in the state. Little did I know how timely and important their concern would be.

The KMA Subcommittee on Domestic Violence became a very unique group made up of physicians, social workers, attorneys, and directors of spouse abuse centers and was given the task of finding ways to educate and disseminate information to all physicians in Kentucky about the great toll to human life violence in our homes had become.

To ignore the consequences of these crimes means to ignore the outcry from our patients for help. The patient's well-being is made up of physical, psychological, and financial boundaries. If any one of these is violated by another family member, it affects the whole being of the individual and the family unit. The single largest cause of women's injuries in the US is domestic

violence. When breast cancer was the most common cause of cancer among women, physicians jumped to the forefront with better exams, better testing and history-taking, and scheduling mammograms to bring that number down. We must be as quick and diligent to do the same with domestic violence crime in our state. We know the problem is real; we know the numbers and costs exist. It is well documented. Now is the time for action. Become your patient's advocate.

During my work on the subcommittee, I was appointed a seat on the Kentucky Governor's Task Force for domestic violence crime. This has educated me on the importance of good communication between all professionals involved with the victims of domestic violence and has given me the opportunity to voice the concerns and questions physicians have to the governing body, which eventually influence state laws on domestic violence. However, I need your help to appropriately represent physicians across this state.

The KMA subcommittee formulated educational material on domestic violence outlining current Kentucky state laws and mailed this information to Kentucky physicians, daycare centers, public school counselors, social services, and others. The subcommittee plans to hold regional meetings for continuing



Baretta R. Casey, MD  
Pikeville

"I became involved with domestic violence crime as a resident in family practice. . . . To ignore the consequences of these crimes means to ignore the outcry from our patients for help."



medical education of health care workers.

On June 16, 1995, I attended the AMA Young Physicians Section meeting in Chicago and was presented the AMA-YPS Community Service Award for my work with domestic violence. I am very honored to receive this award; but, the thanks go to all those who have worked to make our communities a safer and happier place to live.

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*Dr Casey is a past president of both the KMA Medical Student Section and Resident Physician Section and has served on the AMA Advisory Panel on Women Physician Issues.*

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Leah J. Dickstein, MD

Louisville

"I meet with all entering residents during their general orientation, and with residents in individual departments by invitation to speak about some of the health awareness topics."

## HELPING THE WELL-BEING OF MEDICAL STUDENTS/RESIDENTS

**I**N 1977 SEVERAL SOPHOMORE medical students insisted that I "do something" for the next entering medical school class to enable their transition to medical school to be less stressful. Thus, the *Student Hour* program was developed to offer each unit lab group of about 20 first-year students the opportunity to meet voluntarily twice a month with a support team consisting of a senior (ie, retired) physician, an MD-clinical and a PhD-preclinical faculty member, a psychiatry resident, and three or four sophomores. Often they meet over a monthly birthday potluck lunch to share concerns and get advice on general coping techniques.

The *Health Awareness Workshop*, held for four days the week prior to the onset of classes for all entering freshmen, was begun in 1981 to enlarge on the *Student Hour* program. All significant others are invited to

attend all sessions and there is a special children's day as well. Some of the topics include relaxation techniques; time management; the psychobiology of stress and the stress response; toning and chanting; meditation; practical nutrition; medical and personal ethics; substance abuse and impairment; gender discrimination and sexual harassment; sexual, religious, and racial sensitivity and tolerance; personal security; and more. In addition to scheduled talks, new medical students are treated to daily nutritional meals, sports and fun programs, and an evening devoted to the arts. The workshops continue to receive national and international recognition.

In addition, I meet with all entering residents during their general orientation, and with residents in individual departments by invitation

to speak about some of the health awareness topics.

Finally, for women in medicine, I am proud to have founded the Committee of Women Faculty at the University of Louisville School of Medicine in 1981. We usually meet monthly, occasionally with a speaker and formal presentation, often with informal topics, general discussion and recommendations for issues with the Dean. For example, a current medical school task force on the status of PhDs in clinical departments emanated from a woman PhD verbalizing this issue. Annual receptions for women residents and women faculty offer both groups mentoring and networking opportunities.

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*Dr Dickstein is the Associate Dean for Faculty and Student Advocacy at the University of Louisville School of Medicine.*

## A COMMITMENT TO SERVICE FROM THE BEGINNING



Andrea Faulconer  
Louisville

"One of the main reasons students are drawn to the field of medicine is a dedication to service and a desire to make a direct impact on individual people."

**W**HILE PICKING THROUGH the details of the Krebs cycle and pathways of the cranial nerves, it is easy for medical students in the basic science years to forget the big picture — not only the big picture of how all of the basic science information fits together, but also the reason he or she is even in medical school.

The typical medical school interview question is: "Why do you want to be a doctor?" Applicants spend hours trying to prepare a creative answer in an attempt to avoid the trite response: "to help other people." However, the fact is that one of the main reasons students are drawn to the field of medicine is a dedication to service and a desire to make a direct impact on individual people.

In spite of the time demands on medical students, many still make time for what inspired them to pursue the field to begin with: a commitment to service. In addition to other activities, the University of Louisville Medical Student Section of the Kentucky Medical Association focused on service activities this year.

For Halloween, a group of students dressed as witches, cowboys, and clowns to bring treats and games to lift the spirits of children at the Home of the Innocents, a children's shelter in Louisville. As a Thanksgiving project, first and second year student members teamed up for a food drive for Dare to Care which netted almost

1,000 pounds of nonperishable food items.

As an ongoing project, 30 medical students served as mentors to students from Central High School's premedical magnet program. Many of the students come from disadvantaged backgrounds, and the mentor program gives them a role model and friend in professional school. Although the high school students constantly hear about the importance of academics from their teachers, the message is better heard when coming from someone acting as a "big brother or sister" who is just ahead on their desired path. A little encouragement makes all the difference for some of these students who need some support and motivation to continue in their pursuit of a medical field.

Throughout the year, the service activities of the KMA-MSS not only made a difference in the community, but also kept students in touch with their commitment to serve and desire to make a difference in the midst of the details of the basic science years. The KMA-MSS members' dedication to service now reflects the kind of physicians they will become in the future.

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*Ms Faulconer is the immediate past president of the University of Louisville Chapter of the KMA Medical Student Section and has served as delegate to the AMA-MSS and KMA House of Delegates.*



## A SENSE OF COMMUNITY



Linda H. Gleis, MD  
Louisville

"Each of us has special talents and our community is enhanced when we put them all together in an organized way."

**A**S I GREW IN MY PRACTICE in physical medicine and rehabilitation with persons with physical impairments, I came to realize that my patients' outcomes were influenced by more than just the medical care received. From the holistic perspective, there are direct and indirect influences like those linked to insurance policy specifics with covered services; social programs and family dynamics; support systems available; emotional stability and spirituality; coping strategies; focused, informed decision making; physical barriers that prevent interaction in the community; and educational and financial aspects that influence choices available. All of these influences are multifaceted and to tackle each would require the efforts of many. A systematized, organized effort would be needed, I have long since concluded.

My energies have been directed at our community medical society, thus far, but local efforts can then be channeled to a larger network within the KMA and the still larger AMA. One example of this influence has been that of our local work on issues pertinent to domestic violence and that our work has heightened efforts with and by the KMA.

Part of being "recognized" relates to being "heard" by those in leadership positions in the community. As physicians, we spend many hours with our patients or in the direction of patient care, as primary endeavors. However, we also participate in community activities,

usually associated with professional interests and in those community activities associated with social or family interest. Because we are in a "cottage industry" categorization professionally, our individual and collective efforts and participation are not often recognized by others in our community. To address this problem, I have been able to work with our Metro United Way to develop a tracking system through membership in the Jefferson County Medical Society. Therefore, collectively, as a profession, we physicians have been able to be recognized for our efforts in addressing the many needs of those in our community, as well as attracting the attention of others with authority or influence in our community. It has become a win-win situation. These efforts have opened the doors for our physician members to become more involved with many of the community agencies directly and enhance the quality of services provided.

Yes, each of us has special talents and our community is enhanced when we put them all together in an organized way. We shape our own lives in this way and we set the standards for those who will come after us.

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*Dr Gleis is a past president and current First Vice President of the Jefferson County Medical Society and has spearheaded the JCMS/Medical Foundation United Way campaign since its inception five years ago.*

Mary A. "Kitty" Henry, MD  
Louisville

"Involvement there is both selfless and selfish, for one receives a great deal of satisfaction in helping these men and women get back on their feet."

## VOLUNTEERISM HAS ITS OWN REWARDS

**I HAVE BEEN INVOLVED WITH** the Jefferson County Medical Society Outreach Program/Healing Place for the past five years. The program provides both shelter and treatment for chemical dependency for homeless men and has recently begun a similar program for homeless women.

Involvement there is both selfless and selfish, for one receives a great deal of satisfaction in helping these men and women get back on their feet. A recent report shows that due to efforts of the Healing Place, there are currently 65 former "street alcoholics" that are clean and sober after 18 months.

One of my roles as "Director" of the medical clinic is to solicit the

services of subspecialists and hospitals, when needed. It's so nice to be able to say that I've never been turned down. And requests have not been for small procedures, but have included breast biopsies, hip replacements, cardiac catheterizations, to name a few.

Medicine is traditionally one of the "helping" professions and this is just one more manifestation of that role.

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*Dr Henry was recently recognized by the Jefferson County Medical Society for single-handedly recruiting and coordinating the scheduling of some 60 physicians every week at the Healing Place clinic, Blitz House women's clinic, and the Hope House children's clinic.*

Christine Horner-Taylor, MD  
Edgewood

"I encourage all women to participate in organized medicine because it is truly a way to make a tremendous difference for our patients."

## DEDICATION, DILIGENCE AND DETERMINATION

**SIX YEARS AGO, MY MOTHER** was diagnosed with her second primary breast cancer. She was active in the Reach to Recovery Program with the American Cancer Society (ACS) as a volunteer helping counsel women through the same challenges she faced. Last fall, my mother died of metastasis breast cancer. As a dedication to her life, I became involved with the ACS and vowed to work diligently to make a difference for women afflicted with the same disease. In the fall of 1991, I became the medical advisor for the Northern Kentucky ACS Unit. Since then, I have become a board member at the state division level and currently am the vice president for the

division. For the last two years I have had the honor of being the spokesperson for Kentucky on breast cancer issues and of serving on the State Breast Cancer Task Force.

The ACS has targeted certain cancers and is trying to make a statistical difference in their survival rate. Each state has an appointed task force to analyze when women show up with later stages of diseases and why. Then, they work on trying to correct the "whys," ie, mobile mammography vans to underserved areas like Eastern Kentucky to increase access to care.

Two years ago, I had a 34-year-old patient denied coverage for breast reconstruction by Indiana Medicaid



because they did not feel it was "medically necessary." I appealed in a state hearing and won. Shortly thereafter, Oregon initiated a medical plan which did not cover breast reconstruction. Other body parts like the nose, ear, and prosthetic eyes were covered in the Oregon plan. This was an alarming trend with managed care and the government attempting to decrease medical costs. I began a campaign to make sure that breast reconstruction is available to all women with insurance coverage. The National ACS Office agreed with me and has come out with a statement in support of breast reconstruction.

Currently, I work closely with the ACS and the American Society for Plastic and Reconstructive Surgeons (ASPRS) to organize an effort in each state to pass legislation guaranteeing breast reconstruction through insurance coverage. The legislation will be introduced this fall in the 43 remaining states who have not passed this law.

During July I attended a retreat in Laguna Beach, California, for the 21 young plastic surgeons (less than 41 years old) in the country who were recognized as the future leaders for our country's plastic surgery society.

I encourage all women to participate in organized medicine because it is truly a way to make a tremendous difference for our patients. In this time of managed care with "less care" being provided by the insurance companies, we need to make an organized and political stand to protect our patients. The best and most effective way to do this is through organized medicine.

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*Dr Homer-Taylor also serves on several ASPRS committees, including Women and Government Relations, and was just recently appointed to the Young Plastic Surgeon's Committee and the Educational Technology Committee of the Plastic Surgery Educational Foundation.*

## Carol Swarts Milburn, MD

Crestview Hills

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"Not just a witness to change,  
I have been a participant in  
the evolution of medical care in  
this area."

## IMPROVING PATIENT CARE

**HAVE PRACTICED RADIATION** oncology in Northern Kentucky for over 20 years. Formerly in the shadows of Cincinnati, these years have seen this region of the Commonwealth rapidly grow into a vibrant community in its own right. Not just a witness to change, I have been a participant in the evolution of medical care in this area. Long active on local medical staff committees, I have worked to improve the care of cancer patients by promoting cancer registries, adequate staging and archival data, and by demanding outcome studies long before in vogue or required by JCAH.

In addition to managing a busy practice, a commitment to my patients forced me to find time for involvement in the KMA Cancer Committee, activity on a variety of leadership committees for Greater Cincinnati, and most recently, as a

member of the Governor's Gynecologic Cancer Committee assigned to develop practice parameters for screening and diagnosis of cervical, ovarian, and endometrial cancers. I enthusiastically embark on this latest effort, hopeful that a clear and systematic approach can improve care, reduce variation, and lower cost. As President of St. Luke Hospital's Medical Staff in 1993 and 1994, I have had the distinction of being the first female medical staff president in the Greater Cincinnati area.

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*Dr Milburn has also been active in the affairs of organized medicine through the Northern Kentucky Medical Society and KMA, having served many years as a Delegate and Reference Committee member.*

## AN OPPORTUNITY TO INFLUENCE OUR YOUTH

**I AM HONORED TO BE ABLE**

to share with you my enthusiasm about being a Kentucky physician. I find that my life as a physician is continually filled with the pursuit of knowledge, the loyalty of providing superior patient care and a deepening commitment and trust in the practice of medicine. As a pathology resident at the University of Kentucky College of Medicine, I teach a wide variety of students the basis of pathologic disease processes — the fundamentals of Medicine. This experience is more rewarding than I can convey into words. My ingredients for effective teaching are simple: a “workable” plan of action — whether it involves teaching students or living the life of a physician who strives for excellence.

I enjoy a great sense of fulfillment when I explore various aspects of medicine with our youth. I remember, not too long ago, the desire to witness the realities and mechanics of a medical practice through a physician's eyes. I believe that concentrating on the public's perception of a doctor's daily activities is a fundamental part of our leadership role. That is the reason why I try to inform our youth about medicine every chance I get.

When I encountered the opportunity to become the liaison between Kentucky physicians and the Girl Scouts of America, I immediately organized the AMA-Mentoring program with the local Girl Scouts Council in Lexington. We invite all interested women physicians to



Donna Skinker, MD

Lexington

**“I believe that concentrating on the public's perception of a doctor's daily activities is a fundamental part of our leadership role.”**

participate in this exciting teaching/leadership event this fall. We are also examining ways to help young women learn more about health and prevention and will soon apply for an AMA Resident Physicians Section Policy Promotion Grant to achieve this goal.

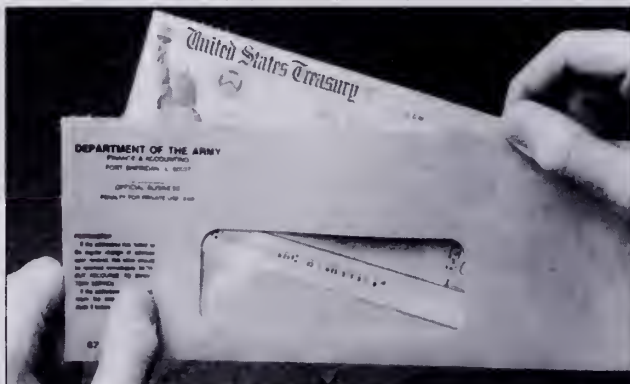
The opportunities for physicians to become teachers of health and disease are endless. What better way to inform the public and continue the promise that we will maintain the standards that American medicine offers? The practice of medicine is an art as well as a science. Only our commitment to our venerable profession will keep it strong. I am continually impressed with my colleagues' visions of excellence that will continue in future medical practices and patient care despite the changes we are witnessing every day. I am honored to be able to influence our youth and to educate them about the various attributes of medicine that many of us enjoy. I am also very pleased to be referred to as a “Kentucky Doctor” and anticipate serving the KMA as much as possible in the future.

*Dr Skinker is the Kentucky Delegate to the AMA Resident Physicians Section, Chair of the Resident Forum for the College of American Pathologists, and current Housestaff President at the University of Kentucky College of Medicine.*



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# A Quiet Talk About Time and the E&M Codes

Steve Aaron, MD

Physician alarm over the Kentucky Health Policy Board's initial requirement to post encounter times for fee disclosure compliance has been quieted, since Dr Beverly Gaines and the other board members were ultimately understanding of our concerns. After reviewing the Evaluation and Management codes, they accepted appropriate rewording.

Equally alarming in January was the Medicare Part B special bulletin and the KMA *Communicator* (p 4) announcement of Navistar's educational/training sessions for the new HCFA/AMA documentation guidelines for E&M services, in which both referred specifically and solely to the *time* component of the new (1992) E&M (old visit) codes. This is alarming, because it suggests an emphasis on *time* in coding that is inappropriate and may indicate a lack of understanding of the codes on their part. Therefore, physicians need to become thoroughly knowledgeable of the design and construct of the E&M codes because we are required to use them and we must understand the rules of this reimbursement matrix to both justify our coding and to protect our interests. If we do not understand the system better than others who have interest in it, then we will be forever at their mercy. Perhaps a review of how *time* figures in E&M coding would be helpful.

As a member of the CPT 4 Editorial Panel when the E&M codes were redesigned in 1992 as part of Physician Payment Reform by HCFA, I am intimately knowledgeable about the AMA Panel's and HCFA's intent for the inclusion of *time* as a factor in

the codes. CPT, 1995, states, on page 8:

**"The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are: history; examination; medical decision making; counseling; coordination of care; nature of presenting problem; and time."** (Count them — time is number seven, not one of the six defining components.)

The use of *time* in the code descriptor has been **"simply to assist physicians in selecting the most appropriate level of the E&M services."** Pages 3 and 4 of the 1995 CPT 4 address *time*:

**"It should be recognized that the specific times expressed in the visit code descriptors are averages (from RBRVS magnitude estimation data) and therefore represent a range of**

**times which may be higher or lower, depending on actual clinical circumstances."**

Further, on page 8, it is stated that only when

**"counseling and/or coordination of care dominates (more than 50%) of the physician/patient and/or family encounter . . . then time is considered the key or controlling factor to qualify for a particular level of E/M services."**

The obvious reason *time* was not made a *controlling* component is that HCFA intended to reimburse for the cognitive *work* in the code and needed a system that would not reward the very slow for spending a long time on a minor problem. Moreover, implicit in the CPT guidelines on the use of *time* in coding is that the times to the left of and under the bell-shaped range of times for any particular service are *not* key. *Time* becomes a controlling or key component only with extended counseling and coordination of care services (ie, those times far to the right and beyond the code-specific curve.) Actual use confirms this is an infrequent occurrence experienced by a few subspecialties.

You will recall that Physician Payment Reform was predicated in large part on an attempt to reward the cognitive process by quantifying the cognitive work in nonprocedural services — primarily the E&M services. The resulting descriptors of these services require precisely-worded, integrated components. No single component can adequately characterize the *total work* involved in

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*Dr Aaron has practiced general and special gastrointestinal surgery in Louisville since 1975. He has extensive coding experience as editor and physician advisor for many ICD9-CM code books and publications on proper coding, and has authored two books on E&M coding. He was a member of the AMA CPT-4 Editorial Panel during the Resource Based Relative Value System integration with the redesign of the Evaluation and Management codes in CPT-4 as part of Physician Payment Reform by HCFA and is uniquely qualified to address the practical issues surrounding this reimbursement matrix.*



the service, hence, the concepts of the key components of a service described by a code:

- the nature (severity) of the patient's problem;
- the amount of history proportionate to the problem;
- the amount of physical examination proportionate to the problem; and
- the amount of decision-making proportionate to the problem.

CPT clearly states that *time* is not a key component of the codes. The Medicare and Medicaid carriers would not allow a physician to code strictly on the basis of *time*. They discourage this because it could reward the very slow for spending a long time on a presenting problem of low severity. Conversely, that's why this system does not penalize fast thinkers, experienced clinicians, or astute diagnosticians by putting them in the position of appearing to charge dishonestly when the total work (*job*) is accomplished expeditiously.

Each E&M code descriptor *quantifies* the work inherent in the code. An obvious question arises: since the work described in the code is quantified by the components other than time, why is time a consideration at all? The practical answer is, as quoted from CPT above, **"simply to assist physicians in selecting the most appropriate level of the E&M services."**

For example, consider this clinical circumstance: after effort, you code the encounter as level II, but the time you have spent is much more than usual (although not due to counseling or coordination of care.) You have probably done more work than initially coded for, and a reexamination may show you should select the next higher level, providing your documentation of key component work justifies that level of service. A cross-check for this up-coding would be to compare your clinical scenario with the clinical

"vignettes" provided for that purpose in CPT.

*Time* modifies the work done and allows going to a higher code when there is reason for prolongation of the encounter by counseling and coordination of care. In such instances the counseling and coordination must account for more than 50% of the encounter. Shorter times than the average ones listed for a service level do *not* drop the code to a lower level. In this regard the CPT code book is to the physician what the flat rate shop manual is to the auto mechanic. You charge and are paid according to the job, no matter how little time it takes you to do the total work of the job.

In 1992 we appeased HCFA by accepting their contention that the Tsaio-Braun RBRVS studies showed *time* spent with the patient face-to-face was somehow equal to the pre face-to-face *time* plus the post face-to-face *time* plus the face-to-face encounter *time*. It is difficult to understand that face-to-face *time* in the office associated with E&M services is "a valid proxy for" (equal to ?) the total work done before, during, and after the face-to-face encounter. But that is how it went down, because that is how HCFA was going to pay for office E&M services, and the AMA compromised to keep CPT as the reimbursement matrix for Medicare.

In contrast to using face-to-face *time* in the office setting, one uses "unit/floor" *time* in the hospital setting. The reason there is a distinction between face-to-face time and unit/floor time relates to bias in the system that defined/derived both concepts, for inpatient services are presumed more credible and inpatient records are more readily verified than office records.

"Unit/floor" time is defined (CPT-p 6) as including pre and post face-to-face time, ie, the time spent away from the patient reviewing data in the

lab in the imaging department, or in charting. This means that in such settings you do take those times into account when you select an appropriate level of service code. As the song says, does anybody really know what time it is? In these situations *you* must know — to avoid fraud and abuse potential if for no other reason. Yet another reason why doctors should do their own coding.

Since descriptors are integrated it is ordinarily inappropriate to emphasize one item from the integrated whole. One's human nature would cause a jump to the wrong conclusions if, eg, only *time* were emphasized. HCFA's understanding of human nature resulted in restriction of payment to face-to-face time with the patient — to counter the human nature of providers. An example of this side of human nature would be one I often encounter at the farm. If I ask my farm hands how long it will take them to move hay from one barn to another, they will immediately respond that it depends on whether they are paid by the *job* or by the hour. Our position in this matter should be that until we are paid by the hour for the complex cognitive work of medical decision-making in a variety of clinical contexts (using a number of cognitive examination skills to accomplish the total work as quantified in the services) then our profession should be alert to resist any attempt to depreciate the value of the total work of the job.

Customarily, much office cognitive work is done outside the face-to-face window of time and may not be appreciated by patients. Predictions that offices will be filled with Gray Panthers clutching AARP-issue stopwatches will come to pass if *time* receives inappropriate editorial emphasis. The whole integrated descriptor and HCFA's recently issued rigorous guidelines for use best explain the work being charged and/or paid for. Become completely

familiar with these codes and guidelines, and share copies if patients ask.

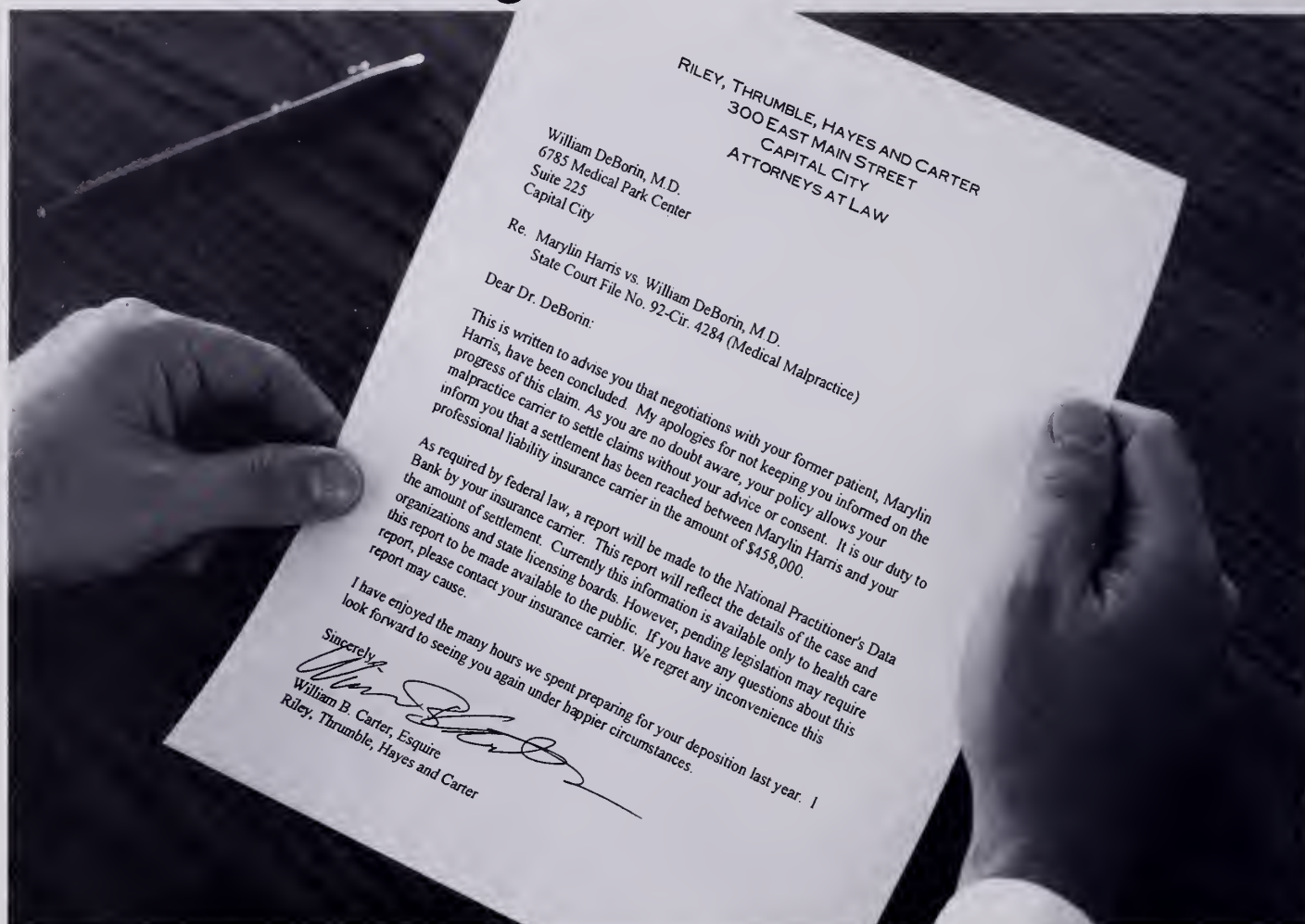
In attending to the business side of medicine under these rules, office habits must change to counter the apparent distortion of face-to-face office *time*. We must perform the work of obtaining and reviewing the history, performing and reviewing the physical examination, and evaluating laboratory and imaging results, and deciding what to do or to not do, and

even communicating with relatives and caretakers and coordinating care with referring or other participating physicians or services *in the presence of the patient*. That may mean dictating the office record or the consultation report or follow-up letter in the presence of the patient and discussing issues and questions with them then. This is the kind of communication patients deserve and it would lead ultimately to better relationships. Such a practice will also

enable you to keep track of time in the face-to-face setting so that if time does come into consideration in selecting a code, you can account for it. Otherwise, in effect, you won't be charging or paid for the pre and post face-to-face *time* you now spend. You should know the codes you use and the rules for their use better than anyone, then let your documentation be your justification for selecting the appropriate E&M code. Time is money and fair is fair.



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# *Interprofessional Code*

## Kentucky Medical Association and Kentucky Bar Association

### *Preamble*

Revised October 16, 1984

### **General Principles**

**D**octors of medicine and attorneys at law, as members of two professions possessing a close personal relationship with those they serve, have established principles of ethics applicable to the traditions and requirements of their respective callings.

The physician has responsibility for the care of the individual, in health as in disease. He must minister to his patient's needs to be best of his ability and in accordance with the high precepts of the Hippocratic Oath.

The attorney is an officer of the court, sworn to support the Constitution of the United States and of the state or states in which he is admitted to practice. As is the physician, he also is pledged to maintain the confidence and to preserve inviolate the secrets of his clients. He will not reject, from any consideration personal to himself, the cause of the defenseless or oppressed, nor delay any man's cause for lucre or malice.

The attorney represents his client as advisor and confidant, as his advocate in legal proceedings and as negotiator in the business and personal affairs of his client. The physician's relationship is parallel, for he is also the advisor and confidant of his patient in matters of health.

### **Interprofessional Relations**

Each profession is obligated by its own stature to respect and honor the calling

of the other. Neither the fact nor the appearance of incompetence, corruption, dishonesty, or unethical conduct on the part of individual members of either profession can be tolerated. It follows then that each profession must vigorously support within its own ranks, as well as in the ranks of the other, those ethical concepts which each has found necessary in the public good. One who has chosen to be a physician or an attorney and has been found competent to be such by appropriate authorities, is vested with high responsibilities and privileges to enable him to serve the public with honor, with dignity, and with effectiveness.

### **This Code**

A statement of ethical principles states a guide to the attainment of the best in interprofessional conduct and practices. IT IS NOT NECESSARILY OF A BINDING CHARACTER, NOR CAN IT BE SO DETAILED TO COVER EVERY CIRCUMSTANCE.

This Interprofessional Code constitutes the further recognition that with the great developments in the science and art of both medicine and law, it is inevitable that the physician and the attorney are drawn into steadily increasing association, as the law calls with increasing frequency upon medicine for its scientific knowledge and for its evaluation of facts so that the rights of individuals and of the government may be appropriately determined before various tribunals.

### **I. RECIPROCAL DUTIES**

#### **A. The Attending Physician and His Patient**

The medical profession affirms the obligation of a patient's attending physician to cooperate willingly with the patient's attorney in supplying facts, primarily available only to him. The physician should accept the further responsibility of explaining such facts in such a manner that the attorney understands them and can determine their relationship to his client's cause. There should be complete cooperation between the physician and the attorney, each assuming his proper responsibility.

It is for the physician to determine the actuality or probability of fact pertaining to his patient's medical condition. It is for the attorney to determine how and under what circumstances such facts are to be appropriately presented.

A physician should never advise on the amount of damages a patient should seek to recover. The proper province of his professional advice is the extent, degree, or percentage of illness, injury, disability, or similar judgments based upon his professional knowledge of the case. He is not expected to understand technical rules of legal liability, or evidence, or of trial techniques. The latter are the exclusive province of the attorney.

#### **B. The Attorney and His Client**



It is a part of the attorney's oath on his admission to the bar of this state that he will not counsel or maintain any suit or proceeding which shall appear to him to be unjust, or any defense, except such as he believes to be honestly debatable under the law of the land. He will employ, for the purpose of maintaining the causes confided to him, such means only as are consistent with truth and honor and will never seek to mislead the judge or jury by any artifice or false statement of law or fact.

In discharge of that oath, it becomes the attorney's responsibility to marshal the facts and to obtain professional and other opinion which, in his judgment, are necessary for his client's case and in a manner consistent with his oath and the ethics of his profession.

It is important that the physician understand that legal proceedings in this country are conducted under what is known as the "adversary system." Under that system the attorney occupies a dual position. He is not only an officer of the court. He is also the single-minded advocate for his client. He does not and cannot properly represent both sides to a dispute.

This system has developed in recognition of the truth demonstrated countless times that justice can usually be satisfactorily accomplished if the two or more contestants can present their point of view to some neutral third person who can weigh the opposing claims. Such claims are usually presented in the form of testimony which is offered in question and answer form. The judge of a court or the officer presiding before an administrative tribunal is the referee who weighs the opposing points of view and the conflicts in testimony. In a sense the judge or administrative officer much more nearly approximates the physician in objectivity. The physician well knows, however, that in some situations it is also possible for medical men to vary honestly and sincerely in their physical findings, their treatment, and their evaluation of illness or injury. In some types of court

cases the parties prefer to let a group of sworn but interested citizens, the jury, weight and "find" the facts.

## II. MEDICAL EXAMINATIONS

(Requested by Attorneys or ordered by Court)

### A. General

1. The law provides that a party to a lawsuit may be required to undergo a medical examination by agreement of the opposing attorneys or under a court order.

2. When an appointment is made for the medical examination of a person, the physician sets aside a part of his day for that purpose. It is, therefore, important that attorneys exert their best efforts to insure that such appointments are kept. The attorney for the party to be examined should give explicit instructions to such party that the physician must be notified in ample time should it become impossible for the party to keep the appointment.

### B. Scope of Examination

1. The physician may take a history and perform such examinations as may be advisable in his judgment to formulate an informed opinion regarding the nature and extent of the party's medical condition.

2. Inquiries should not be made by the physician into matters not reasonably related to the legitimate scope of the medical examination.

3. The physician, following his examination, shall reduce to writing a medical report, following the outline set forth in Section III.B.5. herein. The original report shall be forwarded to the court or person requesting the examination, with copies as directed by the court or by the person requesting the examination.

## III. WRITTEN MEDICAL REPORTS

(Prepared for Courts or Attorneys)

### A. The Attorney

1. Requests for reports from a physician should be made in writing as soon as it is known that the information is needed. The request should be clear as to the specific information desired and the report should be prepared by the physician as promptly as possible.

2. If a report is requested on a physician's patient, the attorney must provide the physician with a written authorization from the patient.

### B. The Physician

1. **Medical Records.** The physician must keep records adequate to supply a patient's attorney all pertinent information regarding the patient-client's medical history.

2. Requests for medical reports should be honored promptly. Undue delays in providing medical reports of bills bearing on a patient's legal rights may prejudice his case.

3. If a physician is unable to make a complete medical evaluation within the time required, he should notify the attorney. In this event, a preliminary report clearly designated as such may serve the attorney's needs until a complete evaluation can be rendered.

**4. Patient's Authorization. The physician must have his patient's written authorization before releasing any report or test concerning the patient. Such authorization is not necessary when the person examined is not a patient of the physician, and the examination is made in connection with a legal claim.**

**5. Content of Report.** The following, where applicable, should be included in the report:

- a. Time, date and place of first visit.
- b. Accurate history of the injury or medical condition, including preexisting disease or prior injury.
- c. Nature of examination and findings.

d. Results of laboratory work, x-rays, and consultations.

e. Opinion including, where possible, diagnosis and prognosis. **Upon request**, the opinion should also evaluate

future physical impairment, necessity for future treatment or surgery, the effect of aggravation of any preexisting disease or prior injury, and length of convalescence. The opinion should likewise include the physician's true opinion on the cause of the patient's condition, and the strength of his opinion in evaluating the cause. In this regard, he should consider and state all objective and subjective matters bearing on this opinion, including, where appropriate, his evaluation of the patient's candor when considered in the light of his own medical knowledge.

f. State if patient's condition is stationary, or if the patient is discharged.

g. Subsequent examination: Include complaints and evaluation of condition, nature of treatment, confinement to hospital or home, referrals to other physicians, patient's progress, results of x-rays, ECGs, EEGs, laboratory work and consultations, and a concluding diagnosis and prognosis (see Item e, above).

h. Enclose separately an itemized statement of medical expense to date. Omit charges for medical reports or attorney consultations or ANY REFERENCE TO INSURANCE.

i. Include estimate of cost of future medical care.

#### IV. CONFERENCES

The physician and the attorney should confer relative to the common problems presented in a particular case. Such conferences should be arranged well in advance of court or other hearing at the mutual convenience of each, in full appreciation that to each profession, time is of the utmost importance. No physician and no attorney should be required to spend unnecessary time in arranging or attending such a conference. The attorney who knows and understands the progress of his client's case, the conflict, if any, of its medical aspects and the probability of settlement or trial should determine the necessity of a conference.

**It is unfair to the patient-client, the physician, and the cause of justice to present a medical witness who has not first conferred with the attorney and who, therefore, may lack a full appreciation of the significance to the case of the particular evidence he is being asked to give. It is equally obvious that the attorney is less able to represent the full interest of his client where he has not had the advantage of full conferences with the physician in advance of presenting the case.**

#### V. DEPOSITIONS AND/OR COURT APPEARANCE

Our system of justice depends on being able to require any citizen's time at a judicial proceeding and to give testimony regarding the case. A conference should be held between the physician and the attorney proposing to call him as a witness at some time mutually convenient before the physician is to testify.

##### A. Court Testimony

Both parties recognize that when it has been determined that the just and proper effect of a physician's testimony cannot be obtained without an oral examination in court, there is a necessity for the dissemination of information of both professions concerning the time problems involved in court testimony. The Medical Association recognizes that the legal profession faces calendar problems, which include the uncertainty of dates in a fluid trial calendar. The Bar Association likewise recognizes that the physicians appointments are made in advance and that physicians are in addition faced with pressing medical problems which sometimes cannot be deferred.

##### 1. Attorney's Duties:

a. The attorney should ascertain whether the physician will be available for a trial term prior to the date assigned for trial at that term. He should not order the attendance of a physician as witness unless necessary and in any case without prior notice and confer-

ence concerning the matters as to which he is to be interrogated unless both the attorney and the physician agree that such conference is unnecessary.

b. The attorney should write to the physician immediately following the docket call to advise the physician of the proposed trial date.

**c. The attorney should keep the physician's office advised of the status of the docket and notify the physician as soon as possible prior to trial of the probable trial date.**

**d. In the event of settlement or postponement, the physician should be immediately notified of that fact.**

e. The attorney should give the physician as much notice as possible of the time when his attendance in court is desired. Physicians should not be asked to appear until the attorney is reasonably certain that they will not have to remain at the courthouse more than a short period of time before being allowed to testify. When the physician enters the court room, he shall, through a court attendant, make his presence known to the attorney trying the case. The attorney shall endeavor to put the physician on the stand as soon as possible after his arrival in the court room subject to orderly and proper presentation of the case.

##### 2. Physician's Duties:

a. The physician has a moral and ethical obligation to give testimony regarding his patient. If the physician undertakes the care of a patient and litigation ensues, the physician should recognize his responsibility to testify as to the medical condition of that patient, subject to the provisions of the Agreement.

b. When given adequate notice of the time when he will be called upon to testify, the physician should make himself available at that time, unless an emergency situation arises which precludes his appearance.

##### B. Depositions

##### 1. Physician-Patient Privilege.

Where testimony is given and docu-



ments are called for by counsel during the taking of depositions in personal injury lawsuits, the usual obligation of confidence in the physician-patient relationship does not exist, and physicians shall furnish any and all pertinent documents, reports, records, notes or x-rays regarding the patient which are requested by counsel for either party to the lawsuit.

**2. Deposition Defined.** A deposition is an official proceeding authorized by law whereby a physician may be required to give testimony and be cross-examined under oath outside of court before a court reporter who is a notary public and in the presence of attorneys representing the parties. He may be requested to produce pertinent medical records at the deposition hearing. He may also be requested to release the records, x-rays, ECGs, EEGs, etc to the notary public for duplication and return.

**3. Time and Place.** The time and place of the deposition should be set **by agreement** with the physician. Unless there is a compelling reason to the contrary, it should be taken at the physician's office **at the time agreed, keeping in mind that an attorney's time has the same value as a physician's.**

**4. Subpoenas — Medical Records.** Production of pertinent medical records may also be required by subpoena duces tecum served on the physician. That subpoena requires the physician to attend the deposition at the time and place stated in the subpoena, and there to produce the specified records.

**5. If Attendance at Deposition a Hardship.** If the time and place described in the subpoena for the deposition creates a hardship, the physician should immediately bring this fact to the attention of counsel taking the deposition.

#### **6. Preparation and Deportment**

a. The Physician. Since the testimony given at deposition hearings may be read at the trial, it is important that the physician prior to deposition pre-

pare himself as for trial and that his attitude and deportment at the deposition hearing be similar to that at trial.

b. The Attorney. An attorney should totally prepare his case from the medical-legal standpoint so that with a careful use of words he can reduce the area of misunderstanding. It is not proper for an attorney to seek to color the professional opinion of the physician. No attorney is justified in abusing, badgering or browbeating any witness, including a physician.

**7. Familiarity with Records.** The physician and the attorney should be thoroughly familiar with their own records and with other related records, including hospital charts and records, at the time the deposition is taken and should have as many of the records at the time the deposition is taken as is possible so that they may be referred to as needed.

**8. Predeposition Conference.** It is to be understood that it is proper to have a predeposition conference between the attorney for the patient and the physician to facilitate the taking of the deposition.

NOTE: If court testimony or a deposition of a physician cannot be set by agreement, the physician's attendance can be required by appropriate legal process. If any doubt arises as to the effect of such legal process, the physician should consult his attorney. A physician should not take offense at being served with a subpoena in the event an agreement cannot be made.

#### **VI. COMPENSATION FOR MEDICAL REPORTS, DEPOSITIONS, COURT APPEARANCE AND OTHER SERVICES**

It is impractical to establish precise rules governing a physician's fees for medical reports, reviewing medical records, conferences, opinions, depositions, court appearances, copies of medical records and other services. It is important, however, that fees be reasonable and that they be discussed in

advance by the physician and the attorney. In this way, the major cause of misunderstanding and dissatisfaction will be eliminated. Generally, the attorney who requests these services of a physician is primarily responsible for prompt payment of the physician's reasonable fees. **Under no circumstances may a physician charge a fee for such services which is contingent upon the result of the lawsuit.**

As a matter of policy an attorney should not request a physician to testify on deposition or in court, nor should he subpoena him, without making arrangements for reasonable compensation. This is not required by law, but is suggested as a matter of fairness and cooperation between the professions. A physician should be compensated for the time spent away from his professional practice, regardless of whether he is used as a witness.

#### **VII. COMPENSATION FOR MEDICAL TREATMENT TO THE PATIENT**

A. The patient, not his attorney, is responsible for paying all bills incurred by the patient for his medical care. While bills should be sent to the attorney on the attorney's request, this does not make the attorney responsible for their payment.

B. When the attorney first obtains a written authorization from his client for the release of medical information, the attorney should request his client to authorize the attorney to take out of the proceeds of any recovery by way of settlement or verdict the funds necessary to pay the physician's then outstanding bill for medical treatment. Upon such authorization being given, the attorney should so inform the physician. Upon recovery, if any, the attorney should, in every case, seek to protect the interest of the physician and see that the physician's bill is paid. In the event there is no recovery, or the recovery is insufficient to pay the bill, the attorney should

so inform the physician. (For suggested form, see Appendix A.)

## APPENDIX A AGREEMENT TO PAY PHYSICIAN FEES

I, \_\_\_\_\_  
hereby authorize and direct my  
attorney, \_\_\_\_\_,  
to pay promptly to \_\_\_\_\_, MD,  
from my portion of the proceeds of  
any recovery which may be paid to  
me through my attorney as a result  
of the injuries sustained by me  
(and \_\_\_\_\_),  
on \_\_\_\_\_, 19 \_\_\_\_\_, the  
unpaid balance of any reasonable  
charges for professional services ren-  
dered by said physician and his asso-  
ciates on my behalf, said profes-  
sional services to include those for  
treatment heretofore or hereafter  
rendered to the time of the settle-  
ment or recovery, as well as those  
for medical reports, consultations,  
depositions and court appearances  
on my behalf. I understand that this  
does not relieve me of my personal  
responsibility for all such charges in  
the event there is no recovery or if  
the recovery is insufficient to satisfy  
such charges.

DATED \_\_\_\_\_

Patient \_\_\_\_\_

APPROVED AND ACCEPTED:

DATED \_\_\_\_\_

Attorney \_\_\_\_\_

violations thereof by a member of either profession should be brought to the attention of the Physician-Attorney Liaison Committee for a determination to be made as expeditiously as possible.

Notice of the nature and pendency of the complaint shall be given to the person about whom the complaint is made.

### ***IX. AMENDMENTS***

This Code may be amended from time to time upon joint resolution of the respective associations represented herein.

This code was originally implemented by a joint committee of the Kentucky Bar Association and the Kentucky Medical Association in 1973.

The revised Interprofessional code was approved in 1984 by the KMA House of Delegates and the Board of Governors of the Kentucky Bar Association.

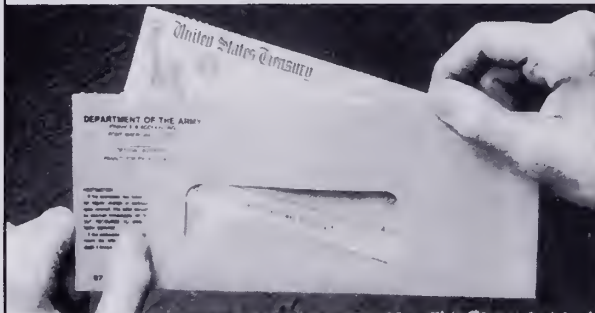
### ***VIII. IMPLEMENTATION OF THE CODE***

The purpose of this Code is to establish, maintain and perpetuate a greater degree of understanding and ethics between the respective medical and legal professions. Any abuse of this Code or



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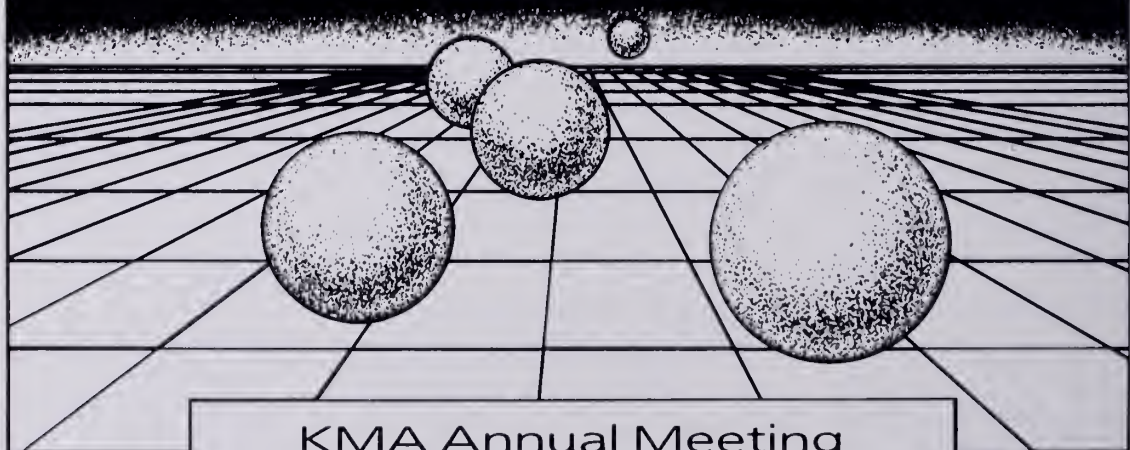
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# A Remembrance of Things Past

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*“Something is irretrievably lost from the daily concourse of experience without some awareness of how we came to be, where we are, and who we are.”*

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It has been estimated that a goldfish encounters a totally new experience every five seconds; its simple neural system is incapable of any recall except for the most rudimentary conditional responses. A human being, on the other hand, not only has the ability of distant recall but the integration of that memory into present events and the unique ability for abstract projection into a contemplated future. Furthermore, there is a vast collective societal memory, recorded at first orally and now by increasingly sophisticated technology, that allows us to place ourselves in the context of that which occurred and that which we anticipate.

The record of past events and individuals, or history, can be arbitrary, subject to diverse interpretation and imperfect, often corrupted at the outset by those who selectively observe. Nonetheless, history forms a seamless fabric of continuity with our past with subsequent relevance to our own existence and experience: to be unaware of what preceded us impairs our judgment of what is and what may be. The same concept holds true for the physician as humanist and heir of a rich legacy of medical tradition and example. Unfortunately, medical history is a study which is becoming increasingly arcane and forgotten, in large part due to our modern preoccupation with the present and its ever changing complexities and demands. As with so many other traditional studies, history as a taught subject has been eroded by the sweeping currents of burgeoning technical data requiring mastery, and the roiling controversies of social relevance and political correctness.

Undoubtedly, the exponential changes within our own lifetime can stretch credulity. It is with some amusement when I relate, for instance, to skeptical medical students that there was no such procedure as a CAT scan available when I was an intern; similarly, I clucked my tongue in disbelief when my old professors told me of “fever bells,” mixing IV solutions every morning, and determining serum electrolytes by flame spectrophotometry. More troubling, a resident recently espoused the opinion that the first atomic bomb was dropped in the 1960s. Certainly, such a lack of understanding of historical perspective does not detract from being a competent physician as scientist nor enjoying the fruits of one’s labors. Nonetheless, something is irretrievably lost from the daily concourse of experience without some awareness of how we came to be, where we are, and who we are.

It would be quaint and anachronistic to even suggest that medical history again be taught to our medical students and residents, or at least made available to them. Such a concept seems out of step with our current values and priorities. Yet, the inherent power of recorded history to evoke forgotten tales and recurrent past lives is compelling and eventually draws to it those who have the time and the interest in it. For those who do not, it is a motivating and absorbing legacy lost to them, leaving their heirs the poorer. As a sage once commented, “the greatest attribute a prophet can possess is a good memory.”

**Jaroslav P. Stulc, MD**



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# The Prescription for Quality Health Care in Kentucky

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KEMPAC participants are either physician members of the Medical Association, their spouses, or medical students. By joining we make a unified voice on issues that affect the medical community.

My husband and I are KEMPAC members. We believe that these are dollars wisely and effectively spent. You can help by joining KEMPAC as a Physician, Spouse, Resident, or

Medical Student. As a grassroots participant in the legislative process, we can become a voice to be reckoned with in Frankfort on health-related issues. KEMPAC contributes 100% of your contributions to candidates who support the legislative goals of physicians. These candidates are selected based on recommendations from KEMPAC members in local districts.

Voter registration drives will be held across the state by Alliance members. Make sure you, your family members, office staff, and friends and associates who are friendly to medicine are registered. If you aren't sure, check with the Board of Elections in your county. Do this NOW! The books close a month before elections, and November is the election for the next Governor. We can make a change happen — VOTE.

**Marla Vieillard**  
KMA Alliance President



*Marla Vieillard*

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**“KEMPAC** *contributes 100% of your contributions to candidates who support the legislative goals of physicians.”*

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Home Address \_\_\_\_\_

Home Phone \_\_\_\_\_ Office Phone \_\_\_\_\_ FAX # \_\_\_\_\_

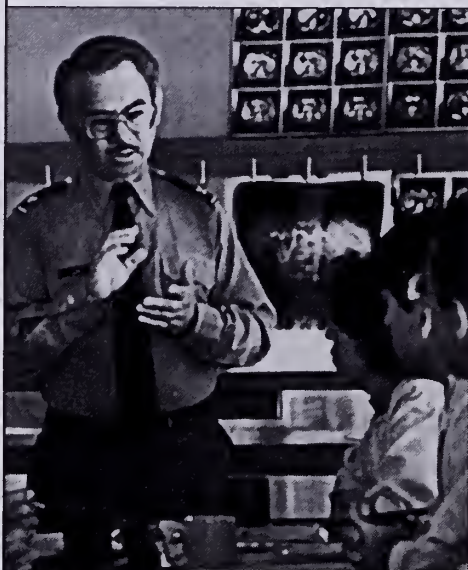
Physician's Name \_\_\_\_\_

Mail form to: KMAA, 301 N Hurstbourne Pkwy, Suite 200, Louisville, KY 40222-8515,  
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Servings Per Container 4

#### Amount Per Serving

**Calories** 100    Calories from Fat 30

#### % Daily Value\*

**Total Fat** 3g    **5%**

Saturated Fat 0g    **0%**

**Cholesterol** 30mg    **10%**

**Sodium** 660mg    **28%**

**Total Carbohydrate** 13g    **4%**

Dietary Fiber 3g    **12%**

Sugars 5g

**Protein** 5g

Vitamin A 4%    •    Vitamin C 2%

Calcium 15%    •    Iron 4%

\*Percent Daily Values are based on a 2,000 calorie diet.

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*A public service of this publication and the U.S. Food and Drug Administration.*

## Memoir of Frank Ray Pitzer 1935-1995

President of KMA 1980-81

by Sam H. Traughber, MD



**F**rank R. Pitzer, MD, was born in Beaver, West Virginia, March 2, 1935, and died of cancer on July 2, 1995. He received his undergraduate education at University of Virginia, University of Tennessee, Knoxville, and Tennessee Tech in Cookeville, Tennessee. His MD and postdoctoral education was completed at the University of Tennessee where he served as Assistant Professor of Pathology from 1964-1965. Doctor Pitzer was a member of the AMA, Southern Medical Association, KMA, Pennyryle Medical Society, Kentucky Society of Pathologists (Past President) and the American College of Pathology. He was advanced to fellowship in the American College of Pathology in 1966. He will be remembered for many things. Among these are: loyalty, activism, and community spirit. Frank's loyalty and medical activism were such a prominent feature that he was affectionately known as "the Godfather" by his closest associates.

Frank Pitzer's community spirit was exemplified by years of service with the Hopkinsville Rotary Club, raising money for the student loan fund and the Salvation Army. He was one of the founders of University Heights Academy where he served as chairman and board member.

His activism involved him in many causes, but was seen time and time again in the political arena. Frank was the man to call to help engineer a change in political structures at all levels.

He served the local medical community as lab director of Jennie Stuart Hospital (now Medical Center), and directed his own private lab. He served as a board member of the county health department hospital board and was a leader in the Pennyryle Medical Society where he served as President and the group's driving force.

Frank served his state as board member of HSA West, board member of the Kentucky Tobacco Research Board, and many committees of the KMA. He served as KMA Trustee for six years and was President of the Association from 1980-81. His vision of the future of medicine was prescient. In his first article for the *KMA Journal* in 1980, he said, "we are going to have to change the way we go about our business . . . physicians now have to become involved in the political process. We can no longer be reclusive in the havens of our offices." He went on to say that our business will be conducted in "an open arena with the scrutiny of government, hospitals, consumer groups and our peers."

Frank's wife, and best friend, Shirley, died in April 1995. She and Frank shared everything, but one of their biggest loves was thoroughbred breeding and racing. Lazy Acres (their farm) was their haven and their pride and joy.

Frank is survived by his parents, Frank H. and Marcella Pitzer, his brother Darrell, his two daughters, Jennifer Pitzer Brown and Rhonda Pitzer Johnson, and three grandchildren.

Frank was a fighter to the end, and will be so remembered by those of us he left behind.





**B**aretta Casey, MD, a family physician from Pikeville, received the American Medical Association Young Physicians Section's (AMA-YPS) Annual Community Service Award during the Association's annual meeting.

Dr Casey was honored for her outstanding work with the Kentucky Medical Association's Campaign Against Domestic Violence.

In her first year of primary care practice in an underserved area of Kentucky, Dr Casey developed and oversaw the implementation of a statewide program to address domestic violence. This program included an educational packet on the issue, which was sent to all physicians, emergency departments, primary and secondary schools, health departments, and day care centers in Kentucky.

As a result of this initiative, a total of 12,000 packets were distributed, 40,000 brochures were ordered and Kentucky medical schools enhanced training for domestic violence awareness in their curricula.

Dr Casey served on the Kentucky Attorney General's Task Force on Domestic Violence, and currently serves on the Kentucky General Assembly Legislative Task Force on Domestic Violence. She has been honored by the Kentucky Victims Coalition for outstanding service on the issue of domestic violence. Dr Casey is an active member of the AMA National Coalition of Physicians against Family Violence, and a former member of the AMA Women in Medicine Advisory Panel.

"The AMA-YPS instituted the community service award for exemplary projects completed by young physicians. This award is intended not just to recognize young physicians for their fine work, but also to raise public awareness of community involvement by young physicians," said Tama D. Abel, MD, AMA-YPS Chair. Dr Abel is pictured on the right above presenting the award to Dr Casey.

## PEOPLE

**Darren Johnson, MD**, an orthopaedic surgeon with the University of Kentucky Sports Medicine Center has received the John J. Fahey, MD, Memorial, North American Traveling Fellow Award of the American Orthopaedic Association.

**Thom J. Zimmerman, MD**, a Louisville ophthalmologist was elected to the United States Pharmacopeia (USP) Committee of Revision during the quinquennial meeting of the United States Pharmacopeial Convention in Washington, DC.

**John P. Bell, MD**, a Louisville psychiatrist, was recently honored at a University of Louisville luncheon for outstanding volunteerism, especially in the field of mental health work.

**Leah J. Dickstein, MD**, a psychiatry professor at the University of Louisville School of Medicine, has been selected as the University's 1994 Trustees Award winner. In addition to teaching, she serves as the school's associate dean in charge of faculty/student advocacy, as well as the academic affairs associate chair and director of the Division of Attitudinal and Behavioral Medicine in psychiatry and behavioral sciences.

Dr Dickstein's concern for the health — physical and mental — of U of L's medical students was among the outstanding qualities cited by her nominators. She teaches classes, spearheads programs, and organizes workshops (often including the fund raising) that help medical students, women, and minorities better their performance.

She has been honored by, and elected president of several professional organizations. She recently received the Psychiatric Education Award from the Association of Academic Psychiatrists. The award recognizes, among other things, her efforts to improve the

quality of life of medical students. She was also recently named Woman of the Year by U of L's Business and Professional Women's Association.

Dr Dickstein has served as president of the American Medical Women's Association, the Association of Women Psychiatrists, the Mid-America College Health Association, and the Kentucky Psychiatric Association. She also served vice presidential stints for the American Psychiatric Association and the American Association for Social Psychiatrists.

In addition to her aforementioned duties, Dr Dickstein also maintains a busy psychiatric practice and supervises students and residents at U of L's outpatient clinic once a week.

## UPDATES

### U of L Professor's Anatomy Videos Hailed as Teaching Aids

The first of five teaching tools that could revolutionize the way medical students learn gross anatomy premiered recently at the University of Louisville School of Medicine.

"The U of L Video Atlas of Human Anatomy," a series of five VHS-format videotapes, is the brainchild of surgeon Robert D. Acland, MD. Dr Acland has dedicated the past 2 years to writing, designing, and editing what he described as the most realistic three-dimensional video anatomy atlas yet produced.

He got help from U of L's Body Bequeathal Program, which gave him access to unembalmed cadavers — "in color and texture the closest thing to live humans," the professor said.

Dr Acland videotapes cadavers in a refrigerated studio assembled solely for that purpose. His camera is

mounted on a robotic arm — an invention that U of L's biomedical engineering department constructed to his specifications. The arm can make an 180-degree arc over a draped table which holds the anatomical section.

On screen, the body part appears to swivel, giving viewers a three-dimensional look at anatomy using a two-dimensional medium. Dr Acland carefully coordinates picture and narration, tapping the expertise of the university's anatomists and videographers to maintain strict accuracy and high production values.

Dr Acland previewed the first tape last year at an assemblage of anatomy scholars. Donald R. Cahill, president of the American Association of Clinical Anatomists and editor of *Clinical Anatomy*, dubbed it "a breath of fresh air" in medical education.

Volume No. 1, which covers the upper extremities, is finished and Dr Acland has begun work on Volume No. 2.

Publishers Williams and Wilkins will hold the copyright and distribute the videos worldwide as they are produced — about one each year for the next 4 years. According to a U of L report, they also plan to investigate a CD-ROM release of the product when the technology advances.

Dr Acland and the publishers have agreed to a price schedule well within the budgets of students and educational libraries, he said.

### FDA Approval for Presurgical Anemia Treatment

Tap Pharmaceuticals Inc recently announced that it has received clearance from the US Food and Drug Administration (FDA) to indicate Lupron Depot® 3.75 mg (leuprolide acetate for depot suspension) in combination with iron supplement for the presurgical treatment of anemia caused by uterine fibroid tumors (leiomyomata).

### KMA Fax Line

The KMA is implementing a fax broadcast service. With this additional communication outlet we will contact you immediately with late breaking important news and events. We are particularly interested in enrolling as many physicians as possible on the KMA fax line prior to the 1996 Kentucky General Assembly.

During the Session, the KMA legislative newsletter will be faxed on Thursday evening and on your desk when you arrive Friday morning. Contact can be made with legislators over the weekend on important legislative events. There is no charge to your office for the transmission.

### Join the KMA Fax Line

Please complete this form and mail to KMA at 301 N Hurstbourne Pkwy, Louisville, KY 40222; phone with details 502/426-6200; or fax to KMA at 502/426-6877.

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Group Name if Applicable

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## NEW MEMBERS

*Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.*

## Boyd

**Philip J. Borders, MD** —P  
PO Box 1447, Ashland 41105  
1988, Indiana U

## Bell

**Mary-Ellen T. Shields, MD** —S  
305 Estill St, Berea 40403  
1977, U of Ottawa

## Bourbon

**Helen M. O'Donnell, MD** —PMR  
128 Gay Rd, Paris 40361  
1980, Albert Einstein Med Coll

## Fayette

**Joseph R. Berger, MD** —N  
1760 S Hillgate Dr, Lexington 40515  
1974, Jefferson Med Coll

**Jitander S. Dudee, MD** —OPH  
2101 Nicholasville Rd Ste 204,  
Lexington 40503  
1989, England

**Michael E. Lally, MD** —EM  
2120 Rollingdale Rd, Lexington 40513  
1978, U of Kentucky

**Christian N. Ramsey, Jr, MD** —FP  
800 Rose St, Lexington 40536  
1970, Emory

**Robert D. Saken, MD** —PD  
101 Prosperous Pl Ste 300, Lexington  
40509  
1979, U of Illinois

## Franklin

**Daniel J. Howley, MD** —N  
314 Stonehedge, Frankfort 40601  
1979, Temple

## Graves

**Johnny W. Williams, MD** —OPH  
PO Box 1029, Mayfield 42066  
1989, U of Louisville

## Hardin

**Daksha P. Mehta, MD** —RHU  
915 Memorial Ct, Elizabethtown 42701  
1981, GS Med Coll India

## Jefferson

**Kendall R. Goldschmidt, MD** —R  
7108 Austinwood Rd, Louisville 40214  
1988, Wright State

**J. Kathleen Moore, MD** —PD  
2323 Hawthorne Ave., Louisville 40205  
1987, U of New Mexico

**Dante J. Morassutti, MD** —NS  
210 E Gray St Ste 1105, Louisville  
40202

1983, U of Toronto  
**Andrew Reisner, MD** —NS  
210 E Gray St Ste 1105, Louisville  
40202

1979, U of Witwatersrand S Africa  
**Leonard S. Sherman, MD** —R  
9931 Wood Wind Ct, Louisville 40223  
1989, Wayne State

**David H. Taylor, MD** —P  
2504 Longest Ave, Louisville 40204  
1990, U of Rochester

**Ring Ring Tsai, MD** —EM  
4006 Woodstone Way, Louisville  
40241

1991, U of Cincinnati  
**Stephen M. Winhusen, MD** —FP  
302 Oread Rd, Louisville 40207  
1991, U of Cincinnati

## McCracken

**Cyrus E. Bakhit, MD** —AN  
2831 Lone Oak Rd, Paducah 42003  
1989, Bowman Gray

**Paul J. D'Amico, MD** —IM  
225 Medical Center Dr Ste 201,  
Paducah 42002

1991, Med Coll of Virginia  
**Michael D. Finn, MD** —AN  
1155 Lakeview Dr, Paducah 42001  
1986, U of Nebraska

## Montgomery

**Lawrence L. Manship, MD** —S  
4791 Howards Mill Rd, Mt Sterling  
40353  
1981, U of KY

## Nelson

**Lloyd A. Manchikes, MD** —AN  
101 Indian Trail, Bardstown 40004  
1982, U of Kentucky

## Northern Kentucky

**Debra F. Schulte, MD** —FP  
103 Landmark Dr, Bellevue 41073  
1982, U of Louisville

## Pulaski

**Robert J. Perzacki, MD** —P  
PO Box 3308, W Somerset 42564  
1986, Med Coll of Wisconsin

## Wolfe

**Dennis B. Campbell, MD** —P  
750 Clifty School Rd, Campton 41301  
1987, U of Kentucky

## Warren

**Thomas J. Young, MD** —HEM  
201 Park St, Bowling Street 42101  
1986, Temple

## Whitley

**Syed M. Shahab, MD** —IM  
1040 18th St, Corbin 40701  
1986, Dow Med Coll Pakistan

**Syed T. Shahab, MD** —C  
1040 18th St, Corbin 40701  
1984, Dow Med Coll Pakistan

## In-Training

## Jefferson

**Ann L. Clark, MD** —OBG  
**Josephine Mei, MD** —PUD  
**John N. Olsofka, MD** —S  
**Patricia M. Purcell, MD** —PD  
**Stephen J. Spanbauer, MD** —IM  
**Scott W. Taber, MD** —S

**KMA**  
**PRE-LEGISLATIVE**  
**SEMINARS**  
**SCHEDULE**  
*See page 397*

**DEATHS****Carl A. Waldemayer, MD  
Butler  
1911-1995**

Carl A. Waldemayer, MD, a retired general practitioner, died May 5, 1995. A 1943 graduate of Kansas City University of Physicians and Surgeons, Dr Waldemayer was a life member of KMA.

**John L. Cassidy, MD  
Covington  
1915-1995**

John L. Cassidy, MD, a retired family practitioner, died May 18, 1995. Dr Cassidy graduated from the University of Cincinnati College of Medicine in 1937 and was a life member of KMA.

**Lundy Adams, MD  
Jeremiah  
1913-1995**

Lundy Adams, MD, a retired general practitioner, died May 26, 1995. A 1943 graduate of the University of Tennessee College of Medicine, Dr Adams was a life member of KMA.

**Horace E. Titsworth, MD  
Paducah  
1913-1995**

Horace E. Titsworth, MD, a retired family practitioner, died June 5, 1995. Dr Titsworth graduated from the University of Louisville School of Medicine in 1938 and was a life member of KMA.

**George F. Gilbert, MD  
Lawrenceburg  
1922-1995**

George F. Gilbert, MD, a retired general practitioner, died June 22, 1995. A 1946 graduate of Vanderbilt University School of Medicine, Dr Gilbert was a life member of KMA.

**Thomas J. Vaughan, MD  
Berea  
1937-1995**

Thomas J. Vaughan, MD, a radiologist, died July 5, 1995. Dr Vaughan was a 1963 graduate of Medical College of Virginia, Commonwealth University, and was an active member of KMA.

**J. Thomas Giannini, MD  
Louisville  
1911-1995**

J. Thomas Giannini, MD, a retired plastic surgeon, died July 5, 1995. A 1938 graduate of the University of Louisville School of Medicine, Dr Giannini was a past Kentucky delegate for the American Medical Association, a past member of the KMA Board of Trustees, and a life member of KMA.

**Clarence E. Quaife, MD  
Louisville  
1917-1995**

Clarence E. Quaife, MD, a retired family practitioner, died July 7, 1995. Dr Quaife graduated from the University of Louisville School of Medicine in 1943 and was a life member of KMA.

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KMA PRESIDENTS  
LUNCHEON**

WEDNESDAY, SEPTEMBER 20, 1995

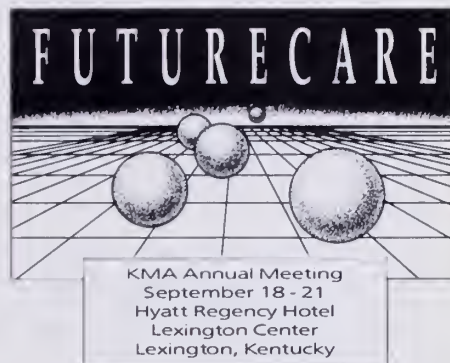
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301 N Hurstbourne Pkwy  
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**Louisville, KY 40222**

New Phone Number  
**502/425-7761**

New Fax Number  
**502/425-6871**



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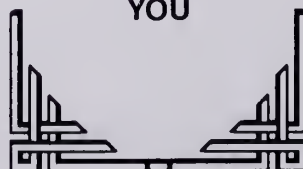
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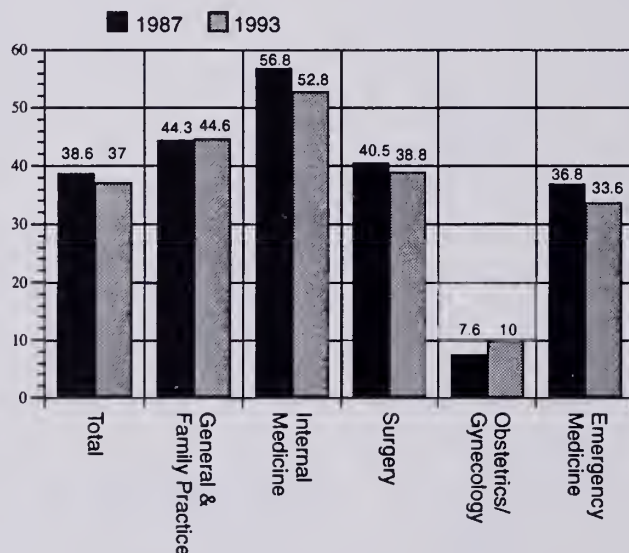
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## Who's Caring for Medicare Patients?

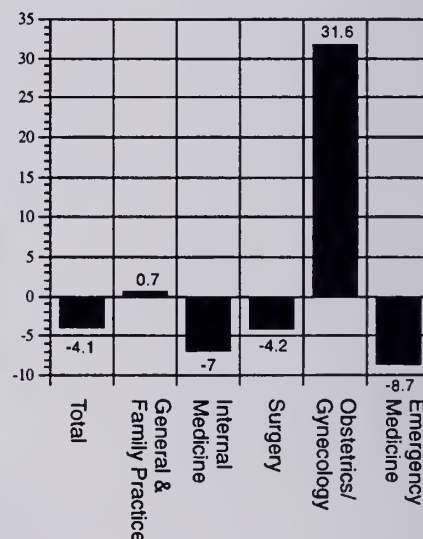
### Chart A

Average number of Physician Visits with Medicare Patients per Week  
Selected Years 1987 and 1993



### Chart B

Percentage Change in  
Average number of Physician Visits with Medicare Patients per Week  
Selected Years 1987-93



Source: American Medical Association, *Physician Marketplace Statistics 1993*

**C**hart A illustrates the average number of total physician visits with Medicare patients per week in 1987—before the Medicare fee schedule was implemented—and after the fee schedule in 1993. Since internists care for more Medicare patients than physicians in any other specialty, the American Society of Internal Medicine is concerned that proposed cuts to the program will impose a hardship on physicians who care for Medicare patients and could cause elderly and disabled Americans to have difficulty obtaining appropriate health care in the future.

Chart B shows the percentage change in care to Medicare patients during the same time period. Chart B suggests that internists are already beginning to reduce the number of Medicare patients seen in their practices.

Under current law, payments for primary care services under Medicare will be cut more than 2 percent in 1996. All other physicians will begin to experience annual fee cuts beginning in 1997—an ultimate 22 percent cut over the next 10 years. These numbers do not include the proposed congressional budget cuts of an additional \$270 billion, some of which may come out of payments for physician services.

**Call for Papers!**

**"Uncertain Times: Preventing Illness, Promoting Wellness"** is the theme for the 1996 International Conference on Physician Health to be held February 7-10, 1996, at the Sheraton San Marcos Hotel in Chandler, Arizona. Presentations dealing with any aspect of physician health, including issues of well-being, impairment, disability, treatment, and education are welcome. Of particular interest are: Stress and Physician health; Epidemiologic data; The effects of violence directed at physicians; Violence occurring within physicians' families; Patient exploitation; Mental illness, including substance abuse; Physical illness and disability; Special populations; Comparative data across states or countries; Physician well-being and family functioning.

For more information or to request an abstract submission form, call Elaine Tejcek, AMA, at 312/464-5066 or FAX your inquiry to 312/464-5841.

**1995****OCTOBER**

**13-14 — Contemporary Management of Common Respiratory Problems, Cincinnati, OH, during the Tall Stacks Celebration. Sponsored by University of Cincinnati Medical Center. AAFP approved CME program. Contact:** Robbie Cornelison, University of Cincinnati Medical Center, PO Box 670528, Cincinnati, OH 45267-0528; phone 513/558-5391; FAX 513/558-5391.

**7 — 12th Annual Ophthalmology Seminar: Management of Diabetic Retinopathy by the Comprehensive Ophthalmologist. Audubon Regional Medical Center, Louisville, KY. Contact:** Cathy Edens, 240 Audubon Medical Plaza, Louisville, KY 40217; 502/636-2823.

**13 — 4th Annual Keynote Symposium: Sleep Medicine '95, Columbus Marriott North, Columbus, OH. Sponsored by Riverside Methodist Hospitals in cooperation with Sleep Medicine Research Foundation, Inc. and the Ohio Sleep Medicine Institute. Contact:** Sleep Medicine Research Foundation, Inc; 614/792-7632.

**23-27 — 47th Annual State-of-the-Art Conference, Sheraton Seattle Hotel and Towers, Seattle, WA. Sponsored by the American College of Occupational and Environmental Medicine (ACOEM). Contact:** ACOEM, 55 W

Seegers Rd, Arlington Heights, IL 60005; phone 708/228-6850; FAX 608/228-1856.

**NOVEMBER**

**5-10 — 26th Family Medicine and Primary Care Review — Session III, Hyatt Regency Hotel, Lexington, KY. Contact:** Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; 800/204-6333; FAX 606/323-2008.

**17-18 — Perinatal/Neonatal Symposium, Radisson Plaza Hotel, Lexington, KY. Contact:** Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; phone 800/204-6333; FAX 606/323-2008.

**1996****JANUARY**

**28-February 3 — Practical Aspects of Diagnostic Radiology/Medical Imaging, Silvertree Hotel, Snowmass Village, CO, sponsored by Vanderbilt University Medical Center. Contact:** Marilyn J. D'Asaro, Manager/Program Coordinator, Div of CME, Vanderbilt University School of Medicine, D-8211 Medical Center North, Nashville, TN 37232-2337; phone 615/322-4030.

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OCTOBER 1995  
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JOSEPH SMITH, M.D.

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VOLUME 93, NUMBER 10

OCTOBER 1995

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**COVER:** On September 20, 1995, Donny M. Clark, MD, of Somerset obstetrician-gynecologist, was installed as the 145th President of the Kentucky Medical Association. Dr Clark's Inaugural Address begins on page 445 and a profile of this very accomplished physician begins on page 466.

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Danny M. Clark, MD

## Inaugural Address

### Danny M. Clark, MD

**T**hank you ladies and gentlemen for bestowing upon me the finest honor a physician in Kentucky can receive from his fellow physicians. I accept the responsibility and office of President of the Kentucky Medical Association with great trepidation but with tremendous pride. I stand before you today fully aware that many of my predecessors carried out their duties with great dignity and integrity. I intend to follow in their footsteps to the best of my ability.

Permit me to take a few moments of your time and outline with you some of my beliefs and what appears to be defining issues within health care. The practice of medicine is in the throes of transition as it has been since the beginning of time. However, Danny Clark is not one of those "skies are a falling" doctors. Being a physician just happens to place me in the category of being one of the most fortunate persons on this planet. Our work is exciting — in most cases we help people — most people admire and respect us — and we are generally well thought of by our patients and our community.

There are many issues confronting medicine today, and I would like to address several of those at this time.

**P**erhaps no other issue has had a more dramatic effect upon health care than managed care.

Managed care strikes at the very heart of traditional medicine and the

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*"Those of us who stand in the breech — the nurses — the physicians — those of us who make life and death decisions every single day do so with a singular goal — make the patient well — relieve the pain — restore patients' dignity."*

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patient's right to choose. The defeat of the Clinton bill may be attributed

to the question of whether patients have the right to choose their own physician. That issue is the single overriding principle which patients and physicians alike in this country can rally around. It is a concept which we as physicians and providers need to openly embrace. Physicians need to be wary of those who advocate taking away patient rights under the guise of reducing costs. Being an obstetrician, I have seen first hand the arrogance of "mis"-managed care. When insurers force women and newborns out of hospitals within 24 hours or promote "Drive through Delivery" without empirical data supporting their contention that this is appropriate medical practice, it concerns me. This is not to mean that patients cannot choose insurance plans which operate under a gatekeeper concept or belong to HMOs and other economic entities which feature expanded coverage but limit access and choice. However, there is a fine line between standard and appropriate medical care and decision-making by persons who have no involvement with the patient.



Reducing health costs by limiting access and choice yet increasing morbidity may be cost effective but it sure doesn't enhance the patient-physician relationship, nor does it insure the delivery of quality care.

---

*"The defeat of the Clinton bill may be attributed to the question of whether patients have the right to choose their own physician. That issue is the single overriding principle which patients and physicians alike in this country can rally around."*

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Those who make critical medical decisions totally disconnected from the patient — those who direct these decisions from "afar" by telephone, arrive at conclusions based solely on costs and criteria. The overriding pressure from the arena in which they operate is always based on economics — the bottom line. Those of us who stand in the breach — the nurses — the physicians — those of us who make life and death decisions every single day do so with a singular goal — make the patient well — relieve the pain — restore patients' dignity.

Physicians, unlike managed care bean counters, bear the moral, ethical and legal responsibilities of our patient decisions. If big business — big insurers — big government wish to continue expanding and strengthening "managed care mania" then legislative remedies are in order

— remedies that tie the decision makers to patient outcome. If managed care by telephone from "afar" is mandated — as is customary in some plans — then patients — the insured — must be prepared to answer the ultimate and defining question — What do you want us, your physician, to do? Deny care? Delay Care? Reduce Care? Who makes the decisions — who bears the responsibility — who answers to the patient or the family?

Physicians stand as the last line of defense in the war for patient choice. We have the opportunity to communicate with our patients. We need to communicate more and get them involved in their health care.

I would be remiss if I did not mention the growing outrage with House Bill 250, the so-called Health Care Reform Bill. House Bill 250 is a classic example of abuse of the public trust by government and the growing infringement upon our lives and property. The stated purpose of "health system" reform was predicated on the needs of the uninsured. That, we were assured, was the single overriding purpose of health system reform. Unfortunately, all Kentuckians received from the 1994 General Assembly and Governor Jones was a massive bureaucracy, total control of our health care, and big taxes. They never addressed the "stated purpose" of health care reform and somewhere along the way the uninsured were forgotten and became totally disenfranchised from the process. House Bill 250 is a formidable challenge. We intend to fully exercise our options during the 1996 Session. We plan to educate our members and our patients regarding the excesses of HB 250. If the General Assembly fails to take us seriously then we will take the issue to the people during the 1996 elections.

The changes in our Medicaid system in the last year have created a real hardship for our patients. As a rural physician, I have seen a number of doctors who no longer participate in the program or who have limited their participation. Reimbursement rates must return to an adequate level. We watched as several excellent physicians with busy practices left rural Kentucky because of the growth in number of Medicaid patients within their practice and low reimbursement rates.

---

*"We must keep our own house in order — the patient and the public must always come first. Only then can the private practice of medicine survive and flourish."*

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This is tied directly to the plight of rural physicians. I hear from my colleagues all over the state how difficult it is to recruit doctors to rural Kentucky. It has never been easy, but with the provider tax, Medicaid cuts, and uncertainty about the DOP program, young doctors find little to entice them to rural areas.

Lastly, we must continue to push for TORT reform. There is not any question in the minds of physicians and liability carriers that the threat of malpractice is responsible for an

ample portion of the cost of health care. We must continue to seek legislative relief. It is imperative that physicians take every opportunity to educate their legislators and their patients regarding this.

**D**uring my career, KMA has provided me with tremendous opportunities and a unique perspective, and I am grateful for it. Let me express publicly today, gratitude to you for providing those challenges and opportunities. More importantly, thanks for the trust you placed in me. I have witnessed first hand the work of our Judicial Council, Peer Review Committees, Board of Medical Licensure, and other mechanisms which reinforce the creed that physicians' first and foremost responsibility is to our patients. I intend to use this pulpit as an advocate for our patients. We must keep our own house in order — the patient and the public must always come first. Only then can the private practice of medicine survive and flourish.

Let me conclude by reassuring the physicians of this state and others that the profession is alive and well, despite House Bill 250 — despite the distortion of the media — despite the rhetoric of the politicians. Every survey taken of the American people reinforces the fact that the pounding and bashing by the media and politicians has not significantly altered patient trust and support in their doctor. Physicians continue to rank in the top three in terms of honesty, credibility and respect.

Medicine is unique among all professions. Those of us who render patient care, those of us who share some of life's most difficult and innermost experiences come away with a unique understanding of human life. By our education — by our training — by our patient

experience — we are granted singular and uncommon responsibility to the public we serve. We are not ordinary. No amount of criticism or envy can take away that special physician-patient relationship.

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*“House Bill 250 is a formidable challenge. We intend to fully exercise our options during the 1996 Session. . . . If the General Assembly fails to take us seriously then we will take the issue to the people during the 1996 elections.”*

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I came to my first KMA meeting 25 years ago because Dr Bob McLeod told me I needed to — and as many of you know — it was almost impossible to say no to Papa Bear. He was my mentor and my friend — and I will always be grateful to him.

Medicine has given a great deal to me, and I want to give credit to those people most dear to me whose support and love make me the richest and luckiest man alive.

I would like to introduce my family at this time.

---

Presented by  
 Danny M. Clark, MD  
 as he assumed the  
 Presidency of the  
 Kentucky Medical Association  
 on September 20, 1995



## **TIMES HAVE CHANGED . . .**

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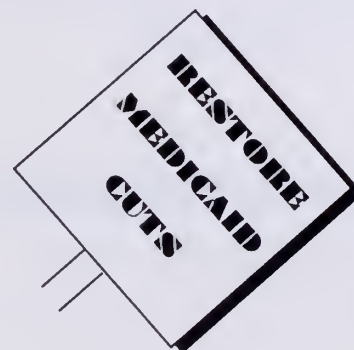
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# MONITORING MEDICINE

In April the KMA Board of Trustees interviewed the major candidates for Governor. In addition, an 11-point questionnaire was presented to each candidate to respond to various concerns. On the following pages is a reprint of Mr Larry Forgy (R) and Lt. Governor Paul Patton's (D) edited comments from the completed questionnaire. The Kentucky Medical Association does not endorse candidates but hopes that these responses will assist you as you vote on November 7 — A. Evan Overstreet, MD, Editor



## KMA PRESENTS PRE-LEGISLATIVE SEMINARS FOR PHYSICIANS AND SPOUSES



DISTRICT	DATE	LOCATION	TIME
1st	October 25	Paducah Country Club	6:30 PM
2nd	October 24	Owensboro/Daviess Co. Hospital	6:30 PM
3rd	October 30	Madisonville-Trover Clinic	6:00 PM
4th	October 5	Elizabethtown-Stonehearth Restaurant	6:30 PM
5th	October 16	Louisville-Jefferson Co. Medical Society	6:00 PM
6th	October 23	Bowling Green-Greenview Hospital	7:00 PM
7th	October 9	Frankfort-Capital Plaza Holiday Inn	6:30 PM
8th	September 28	Florence-Holiday Inn	6:30 PM
9th	October 18	Cynthiana-Platters Restaurant	6:30 PM
10th	October 10	Lexington-Red Mile	6:30 PM
11th	October 11	Richmond-Pattie A. Clay Hospital	6:30 PM
12th	October 31	Danville-Danville Country Club	6:00 PM
13th	October 19	Ashland-Bellefonte Country Club	7:00 PM
14th	October 17	Pikeville-Green Meadows Country Club	6:30 PM
15th	October 12	Corbin-Quality Inn	6:30 PM

**NOTE: Each district member will receive individual mailing with time, meeting site, etc.**

The KMA Public Education Committee, Committee on State Legislative Activities, and KEMPAC present special Pre-legislative Conferences designed for physicians and spouses. Topics include:

- Disseminating information and strategy to support effective lobbying
- Defining and prioritizing medicine's 1996 legislative goals
- Political grassroots--the 1996 election cycle and beyond
- Lobbying--what to say--how to say it--when to say it

### HR 250 REPEAL OR AMEND

- \* Discount Option Program
- \* Free Medical Records
- \* Practice Parameters



## KMA QUESTIONNAIRE FOR GUBERNATORIAL CANDIDATES

### REPUBLICAN



**Larry Forgy**

### DEMOCRAT



**Paul Patton**

**What is your position on the provider tax?**

*Generally speaking, the provider tax is inequitable and unfair and should be reconsidered in any general tax reform.*

*I am absolutely convinced that this tax will reduce the number of high quality physicians practicing in Kentucky, and that it will adversely effect quality of health care for all Kentuckians.*

**What is your position on the physician component of the provider tax?**

*I favor the repeal of the provider tax on physicians and other non-institutional providers.*

*That's a price too high to pay. We will eliminate the provider tax on physicians. I alone called for repeal of the provider tax on physicians last December. If we are to attract the smartest and hardest working people into medicine, we must develop a system which rewards them according to their contributions to society.*

**Will you endorse and support repeal of the physician component of the provider tax during the 1996 regular session of the General Assembly?**

*I will propose significant reductions in the first biennial budget and complete elimination of the tax in my second budget, if not already accomplished.*

*While many other states have a provider tax, only Kentucky and West Virginia have a 2% provider tax on physicians' gross revenue. I am willing to take the short-term heat in order to do what is in the best long-term interest of the people of Kentucky.*

**Do you plan substantial changes in the operation of the Cabinet for Human Resources and Medicaid?**

*The entire structure and operation of CHR will be on the table for consideration. Some major changes probably need to be made.*

*We will make major changes in the operation of the Cabinet for Human Resources. I will appoint Steve Henry, MD, as an interim Secretary of the Cabinet for Human Resources to bring a physician's viewpoint to that major operation of Kentucky state government.*

## DOES **NOVEMBER 7** MEAN SOMETHING TO YOU?

The Kentucky Educational Medical Political Action Committee (KEMPAC) would like to remind you that Tuesday, November 7, is **Election Day** for the General Election, and remember:

**GET OUT THERE AND VOTE!**

**You CAN** make a difference with your vote!!

	Larry Forgy	Paul Patton
<b>What is your position on privatizing Medicaid?</b>	<i>"Privatizing" Medicaid is simply a political ploy on words. In the strictest sense, privatizing would mean abolishing Medicaid as a government program with private enterprise assuming the responsibility. This is simply not feasible with a federally sponsored program of this type. We do plan to "mainstream" the Medicaid population in traditional health insurance coverage of significant savings and down-sizing of government.</i>	<i>I believe we can save major money without reducing services by some sort of privatization of Medicaid. I don't say that insurance companies are necessarily the way to go but some kind of privatization will definitely be better than what we have. We need the provider community's input into the solution of this problem and Steve Henry and I will seek that input.</i>
<b>What is your position on the recent dramatic physician reimbursement reduction in Medicaid?</b>	<i>I believe it to have been shortsighted and unnecessary. Sufficient surpluses were available to continue adequate payment for physician services. The long term result may be loss of access for low income people. "Mainstreaming" the Medicaid population through health-insuring organizations will resolve the reimbursement question to some extent since it will be subject to marketplace forces.</i>	<i>Physicians must be fairly reimbursed for their services. We need the help of physicians to reduce fraud, abuse, overuse, and improper use of the Medicaid program.</i>
<b>Most major health insurance plans employ a physician medical director to oversee the medical component of plans. Would you consider employing such a professional to consult with the Secretary, CHR, on needed policies?</b>	<i>I would have no particular objections to having a medical doctor to oversee the medical component in the Medicaid program.</i>	<i>Medical decisions must be made by physicians. A state bureaucracy cannot practice medicine without the direct involvement of a physician.</i>
<b>CHR is an enormous bureaucracy. Have you given any thought to separating Medicaid from CHR and establishing a separate Cabinet for Health Services?</b>	<i>Serious consideration will be given to establishing a separate entity for Medicaid and possibly other health programs. At minimum, responsibility for various aspects of Medicaid administration and policy will be consolidated under a single office. Responsibility is currently dispersed throughout CHR.</i>	<i>CHR is 40% of state government. As such, it will receive an appropriate portion of my personal attention. I understand that CHR is too large for any one individual to oversee. I plan to split it into two cabinets, one for families and children, the other for health services.</i>



	Larry Forgy	Paul Patton
<b>Physicians and their patients have a number of concerns with House Bill 250. What is your general perception of the legislation and its performance to date?</b>	<i>We believe that the entire "Clinton-type experiment" on health care reform should be on the table for reconsideration, change or repeal.</i>	<i>The insurance reform portions of HB 250 are not fully implemented and my position is to see how this portion works and be willing to take a second look as problems develop.</i>
<b>Several legislators and groups have called for repeal of HB 250. Do you support repeal of all or part of HB 250? If so, of what portion do you disapprove?</b>	<p><i>We have particular reservations concerning:</i></p> <p><i>a. The Health Policy Board would seem to preempt the governor and executive branch as the focal point of health care policy and initiatives.</i></p> <p><i>b. Restriction of health insurance offerings to four or five state approved plans. We believe this represents unnecessary government intrusion on free enterprise and individual choice. It would seem to represent flawed logic in that the same objective of comparability for cost comparison could be achieved by requiring three or four standard plans, but not limiting other choice.</i></p> <p><i>c. The Purchase Alliance, an experiment which simply invokes another broker in the system and may increase the cost of public employees' benefits.</i></p> <p><i>d. The Discount Option Program which was ill-conceived and has grossly missed the objectives of extending care to the uninsured.</i></p>	<i>I will look closely at HB 250 and its effect on health care delivery in Kentucky and be willing to correct those problems which surface.</i>
<b>The KMA supports an amendment to Section 54 of the Kentucky Constitution that would permit the General Assembly to place a limitation on noneconomic awards. Would you support submission of this amendment to the voters of Kentucky for their ratification or rejection?</b>	<i>I reserve judgment on this point pending federal action. However, your membership should know I am not a "plaintiffs" lawyer and have over time devoted my law practice to commercial matters.</i>	<i>As with any proposition, I would need to look at the details of any proposed amendment to the Kentucky Constitution but I would tend to support on amendment which would reduce the need for defensive medicine, when no other need for treatment is indicated for medical purposes.</i>

**KEMPAC**, with the help of the Kentucky Medical Association **Alliance**, is conducting a voter registration drive.

If you are not registered to vote, please contact your County Clerk's office, the KEMPAC OFFICE 502/426-6200, or a KMAA member to receive a voter registration card.

# Intrafamilial Spread of Epstein-Barr Virus

Michael W. Simon, MD, PhD

*Epstein-Barr (EBV) virus is a common contagious illness encountered during childhood. It is spread through oral secretions, however it has a low rate of transmission within a family. This article reports EBV illness among three children in the same family.*

A number of different contagious illnesses may be passed between susceptible family members. The most frequent and best known are upper respiratory tract infections produced by the common cold viruses, picornavirus, paramyxovirus and coronavirus.<sup>1</sup> Intrafamilial spread of mycoplasma is well documented with new cases developing every 2 to 3 weeks.<sup>2</sup> Seasonal and sporadic cases of influenza A may be transmitted between family members.<sup>3</sup> Tuberculosis is becoming more prevalent and may be spread from elderly family members with active infection to children.<sup>4</sup>

The Epstein-Barr virus (EBV) is a frequent cause of communicable illness during childhood.<sup>5</sup> However it has a low frequency of intrafamilial spread.<sup>6</sup> This is surprising since infected individuals have prolonged oropharyngeal excretion of EBV.<sup>7,9</sup> The true incidence of EBV illness may be underreported because most cases produce a mild illness with nonspecific symptoms.<sup>9-14</sup> This report describes spread of EBV illness among children within the same family.

## Case Report

A 6-month-old male had a several week history of fever, irritability, poor feeding, purulent nasal drainage, and congestion. Examination showed an emaciated child with exudative pharyngitis. He had upper airway congestion and serous otitis media. A complete blood count revealed a white blood cell count of 13,300, hematocrit 33%, and platelet count 173,000. The differential showed

18% neutrophils, 2% monocytes, 80% lymphocytes, with 6% having atypical morphology.

Over the next 3 weeks, this child continued to have poor feeding, congestion, and sore throat. Reexamination showed he had developed a right ear infection, with thick tenacious post nasal drip and inflamed throat. He was treated with Erythromycin-Sulfisoxazole and symptomatic measures.

Ten days later the child developed fever of 103°, cough, and respiratory distress. Examination was remarkable for rales throughout the lung fields. He was diagnosed with pneumonia and admitted to the hospital for further evaluation and treatment. Intravenous fluids were administered as well as general supportive measures. He received 3 days of intravenous Ampicillin. Additional laboratory studies during the hospitalization included a sweat chloride with a value of 31 (normal less than 55) and blood and urine cultures, both negative for growth after 3 days of incubation. An Epstein-Barr virus profile was collected. The child improved and was discharged after 3 hospital days. The profile was positive for the nuclear antigen antibody, a pattern for children consistent with convalescent EBV illness (Table 1).

Routine follow-up 2 weeks later showed him to have a normal examination and to be playing, resting, and feeding well. He has returned to day care without sequelae.

The 3-year-old sister began feeling ill approximately 1 month after her brother became ill. She had complaints of earache, sore throat, fever and congestion. Examination showed her to have infected ear drums and an inflamed throat with purulent post nasal drip. She received Ceclor and symptomatic measures. Ten days later she had fatigue and persistent congestion. The examination showed her to have serous otitis media, post nasal drip, and cervical adenopathy including palpable anterior cervical nodes. Symptomatic measures were continued. Two weeks later she



## Epstein-Barr Virus

Table 1: Epstein-Barr Profile

	6 month	3-year-old	6-year-old
Epstein-Barr nuclear antigen antibody	1.66 (low positive)	6.08 (mid positive)	6.64 (high positive)
Epstein-Barr EBV-VCA IgG	0.79 (negative)	2.53 (positive)	1.67 (positive)
Epstein-Barr EBV-EA IgG	<1:20 (negative)	<1:20 (negative)	<1:20 (negative)
Epstein-Barr EBV-VCA IgM	Negative	0.17 (positive)	0.20 (positive)
Interpretation Stage of Infection	Convalescent	Acute	Acute

had worsening fatigue with long periods of sleep and spent little time engaged in play activities. She had developed a pattern of intermittent fever, which was more prominent in the afternoon, and continued to have post nasal drainage. A complete blood count revealed a white blood cell count of 5,600, hematocrit 35%, and platelet count of 171,000. The differential showed 25% neutrophils, 70% lymphocytes, 2% monocytes, and 3% eosinophils. An EBV profile was collected and showed her to be in the acute phase of illness (Table 1). At routine follow-up 2 weeks later, she was noted to be improving, but continued to have intermittent fever and occasional stomachache.

The 6-year-old sister was evaluated for fever, achiness, and fatigue 6 weeks after onset of illness in her 6-month-old brother. Her throat was noted to be erythematous, with a thick post nasal drainage. She had palpable anterior cervical nodes. A complete blood count revealed a white blood cell count of 9,100, hematocrit of 36%, and platelet count of 292,000. The differential showed 54% neutrophils, 39% lymphocytes, 6% monocytes, and 1% eosinophil. The EBV profile showed her to have acute phase EBV illness (Table 1). She continued to have stomachache and fever intermittently but overall showed continued improvement.

The mother reported that the father became ill with sore throat, fever, swollen cervical glands, and fatigue during the interval between onset of illness for the 3- and 6-year-old sisters. He did not seek medical attention and appeared to return to normal in two and one half weeks.

### Discussion

The Epstein-Barr virus is a common cause of in-

fection in childhood.<sup>5</sup> It is easily transmitted through contamination with oropharyngeal secretions.<sup>7,9</sup> However, spread within a family is unlikely, with fewer than 10% of all household contacts acquiring the virus.<sup>6</sup>

Children are more likely to acquire the virus from nonfamilial sources.<sup>10</sup> In this report the 6-month-old was the first family member to become ill, probably acquiring the virus from day care. He either passed it to both siblings or the 3-year-old who in turn passed it to the 6-year-old. It is possible that the children were independently infected from another source or sources. However, EBV has an incubation period of 14 to 60 days, making it likely the cases resulted from intrafamilial spread.<sup>7,8,15</sup> The father could have acquired the virus from the 6-month-old or the 3-year-old. Intrafamilial transmission has been reported for another DNA virus, cytomegalovirus.<sup>16,17</sup> It is possible that multiple family members may be simultaneously ill with EBV.<sup>6</sup>

The diagnosis of EBV infection may be made through the combination of clinical, history, physical exam, and laboratory studies.<sup>10,18,19</sup> The complete blood count and heterophile tests have long been the standard detection methods for EBV. However, the heterophile may be falsely negative in younger children, or positive for a prolonged period of time in older children, confusing the diagnosis of EBV illness.<sup>5,20</sup> Testing of the blood for antibody specific to EBV makes it possible to more specifically diagnose EBV and the stage of illness. The 6-month-old child was diagnosed with convalescent EBV illness through the profile. His sisters were also negative for the EA antibody. As many as 30% of all children with EBV may have a negative EA antibody.<sup>5</sup> The 3- and 6-year-old sisters did not have atypical lymphocytes but were diagnosed with acute EBV illness based upon their examination and antibody pattern in the profile.

The 3- and 6-year-olds had the common non-specific symptoms of EBV: stomachache, fever, sore throat, fatigue, and a general feeling of not being well. These are common manifestations of EBV illness.<sup>10,20</sup> The children in this report also had common complications of EBV illness. The 6-month-old and 3-year-old had otitis media and sinus infection, both occurring in a significant number of children with EBV illness.<sup>9</sup> Young children are more likely to develop otitis and sinusitis due to hypertrophy of the tonsils and adenoids. The 6-month-old also had pneumonia.

Easy fatigability, depression, and possible re-

lapses may occur during the convalescent phase of EBV illness.<sup>5,9</sup> The baby and father are back to normal but the two daughters are still convalescing. The recovery of each individual is variable but should be complete. It may take several months to feel well and return to full activity.

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# Carotid Artery Occlusion After Dog Bite

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*The etiology of most penetrating neck injuries is caused by missiles or stabbings. Irrespective of the cause of injury, management strategies require that life-threatening injuries to underlying deep neck structures such as esophagus, trachea, or carotid artery be promptly identified. A case is reported in which occlusion of the common carotid artery resulted from a dog bite to the neck. The patient presented to the emergency department with four neck lacerations but lacked focal neurologic symptoms suggestive of such an underlying deep neck injury. The carotid injury was identified by preoperative angiography and was repaired with a reversed saphenous vein interposition graft. The patient had full recovery without neurologic sequela. While injuries to deep neck structures as a result of animal bites are rare, these patients should be evaluated according to accepted protocols to exclude or identify such life-threatening injuries.*

The evaluation of patients with penetrating neck trauma, particularly as regards the diagnosis and management of associated vascular injuries, has been the subject of considerable investigation.<sup>1-8</sup> Penetrating neck injuries that result in vascular injury are usually the result of gunshot wounds or knife stabbings. A review of data collated from a number of published series<sup>1-8</sup> demonstrated that the cause of penetrating neck injuries was due to bullets (gun shot and shotgun injuries) in 41.5%, stab wounds in 56.6%, and attributed to "other" causes in only 1.8%. We report a case of carotid injury that resulted from an unusual penetrating injury, that being a dog bite to the neck. This case report underscores the need to manage penetrating neck wounds according to accepted algorithms, irrespective of the cause of injury.

## Case Presentation

A 43-year-old man was admitted to the emergency department after sustaining a dog bite to the left

neck. The patient, who had been drinking alcohol prior to the injury, had provoked the dog into the attack. He stated that his neck was grasped and held in the jaws of a large dog (Chow). The dog did not release its grip until a bystander clubbed the dog with a rod. The patient indicated that he sustained momentary loss of consciousness and reported that there was a "large" amount of bleeding from the neck wounds at the scene of injury. He denied symptoms of paralysis, paresis, numbness, hoarseness, difficulty swallowing, shortness of breath, or hemoptysis/hematemesis. He was taken to a local hospital and then transferred to the University of Kentucky Medical Center for further evaluation and care.

On admission to the emergency department, the patient was awake and alert. His vital signs included: blood pressure, 114/74 mm Hg; pulse, 79/min; respiratory rate, 16/min; and EMV, 15. There were four irregular lacerations on the left side of his neck: two lacerations located in the anterior triangle (4 and 2 cm long) and two lacerations located in the posterior triangle (2 and 6 cm long). Each laceration penetrated the platysma muscle. At the time of evaluation, the patient had no hematoma, ecchymosis, or active bleeding associated with the wounds. The patient was breathing comfortably and had no hoarseness. His neurologic examination was normal. Admission laboratory values included a hematocrit of 33.2%, normal electrolytes, normal protime and partial thromboplastin time, and a blood alcohol level of 152 µg/dl.

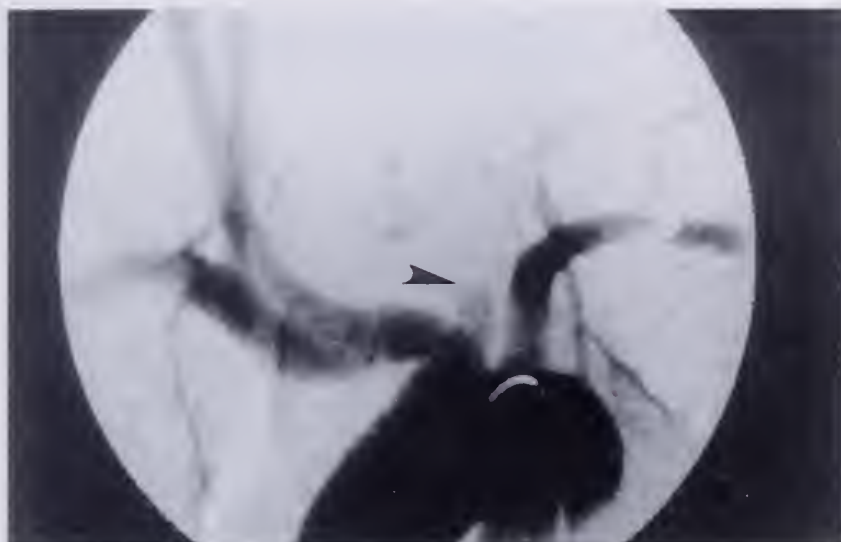
A cerebral angiogram was obtained as part of our protocol to evaluate stable patients with penetrating neck injuries. This study demonstrated a normal right carotid artery, a dominant right vertebral artery, and occlusion of the proximal left common carotid artery (Fig 1). Neither the left internal or external carotid arteries were visualized on the angiographic study. Because the results of the angiogram were obtained 14 hours after the injury, a carotid Duplex examination was obtained which verified patency of both the inter-

nal and external carotid arteries distal to the carotid bifurcation. The patient was anticoagulated with heparin, and after obtaining a barium swallow that showed no extravasation, was taken to the operating room for carotid artery repair.

At operation, the carotid sheath was exposed through a vertical incision along the anterior border of the sternocleidomastoid muscle. There was evidence of recent hemorrhage within the carotid sheath. A through-and-through puncture wound of the facial vein was controlled by ligation and division. The internal jugular vein was mobilized and was without injury. Proximal control of the common carotid artery and distal control of the external and internal carotid arteries were obtained away from the area of hematoma. After clamping the external carotid artery, the stump pressure in the proximal internal carotid artery was measured. The stump pressure was 60/51 mm Hg (mean, 54 mm Hg) while a systemic pressure of 108/55 mm Hg was simultaneously noted. Based on these pressures, a temporary shunt was not used. The remainder of the carotid bulb was exposed and a puncture wound in the common carotid artery, immediately proximal to the carotid bifurcation, was found. The common carotid artery was opened longitudinally through the puncture wound. The intima of the common carotid artery had been sheared away from the underlying vessel which in turn created an intimal flap that began at the puncture site and had dissected distally to occlude the carotid bifurcation (Fig 2). Because of the extent of the injury, the damaged common carotid artery segment was resected and an interposition, reversed saphenous vein graft was used to repair the vessel. The remainder of the neck exploration was normal. The operative incision was closed and the neck lacerations were debrided and closed. The patient awoke from anesthesia without neurologic deficits and had no hoarseness or dysphasia. He was discharged on the second postoperative day.

## Discussion

Patients with animal bites are infrequently treated in emergency departments. In a report by Kizer, animal bites accounted for 1.2% of all surgical problems managed in a busy emergency department.<sup>9</sup> In his series, 72% of all animal bites were caused by dogs, of which 43% were incurred when the animal was provoked. Bites to the head and neck were noted in 21% of dog bites, and were more frequent in the pediatric age group.



**Fig 1** — Angiogram demonstrating the occlusion of the carotid artery (arrow head). The defect seen in the left subclavian artery is artifact.



**Fig 2** — Intraoperative photograph demonstrating the site of the puncture wound to the common carotid artery (arrows) and the intimal flap (arrow head) that occluded the carotid bifurcation. The internal carotid (IC), external carotid (EC), and common carotid (CC) arteries are identified.



## Carotid Artery Occlusion

No mention was made in this study of an animal bite that resulted in injury to a deep neck structure. To our knowledge, the current case is the only report in the English literature in which a carotid artery injury resulted from an animal bite.

Patients with penetrating neck injuries who are unstable should undergo emergent operative exploration. However, the management of penetrating neck injuries in stable patients has been debated. As an aide for the evaluation and management of these neck injuries, the neck has been divided into three zones.<sup>10</sup> Zone I is the area of the neck below the sternal notch, Zone III the area of the neck above the angle of the mandible, and Zone II the area of the neck between the sternal notch and the angle of the mandible. Because vascular structures, specifically the carotid artery, are difficult to expose in Zones I and III, it is generally accepted that stable patients with penetrating injuries in these areas should undergo angiography to help plan the operative approach. The management of Zone II penetrating neck injuries, however, has been more controversial. Some have advocated mandatory neck exploration for all wounds that penetrate the platysma because of concern of false negative diagnostic angiographic, barium, and endoscopic studies.<sup>6,8</sup> However, mandatory neck exploration results in a high number of negative explorations (often greater than 50%), so as a result, others have recommended a more selective approach to the management of Zone II penetrating neck wounds in stable patients.<sup>1,5</sup> When this management algorithm is used, operation is undertaken if the results of angiography, barium swallow, pharyngoesophagoscopy, and/or tracheoscopy are abnormal.

Despite the unusual etiology of the injury presented in this case report, a bite to the neck represents a penetrating injury and as such deserves a comprehensive evaluation according to accepted protocols. In the case described, the location of the injury was Zone II of the neck. Either the combination of angiography, barium swallow, and endoscopy (as was initiated in this case) or operative exploration would have been

appropriate management. Indeed, the large size of the animal (Chow dog), the history of brief loss of consciousness, the need for forcible removal of the animal from the patient, and in particular, penetration of the platysma muscle were indications that pointed to the potential severity of the injury and mandated thorough evaluation. However, because there were no focal neurologic abnormalities, no evidence of active bleeding or neck hematoma, and the unusual etiology of the neck lacerations, there may have been a tendency to forego diagnostic evaluation, which in this patient would have resulted in missing a significant injury. Thus, this case serves as a reminder that serious injuries may be present despite an innocuous presentation or external appearance of penetrating neck injuries. Therefore, it is emphasized that injuries that penetrate the platysma muscle must be thoroughly evaluated, either with neck exploration or diagnostic studies to rule out a serious injury to vital structures within the neck.

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# Smokeless Tobacco Use Among Adults in Kentucky: 1994

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*We assessed the 1994 prevalence of smokeless tobacco use among Kentucky adults  $\geq 18$  years of age. 649 adults, contacted through a statewide random digit dialing procedure, completed an 18-minute telephone survey which included questions on current and former use of chewing tobacco and snuff. Overall, 4.5% of the sample (95% confidence interval [CI] = 2.95%–6.15%) claimed to currently use smokeless tobacco. Among males, 9.9% (95% CI = 6.1%–13.3%) claimed to currently use smokeless tobacco. Use of chewing tobacco exceeded snuff use by 2 to 1. No women were current users of either chewing tobacco or snuff. A typical current user was male, was over 45 years of age, did not graduate from high school, and lived in a rural or Appalachian county of Kentucky. Former users comprised 17.3% of the sample; all but one of these were male. By the year 2000, the overall prevalence of smokeless tobacco must be reduced by half if Kentucky is to meet its public health objective that no more than 2% of Kentuckians use smokeless tobacco.*

The use of smokeless tobacco is a significant public health problem in the United States. Smokeless tobacco, which is sold as snuff and chewing tobacco,<sup>1</sup> increases the risk of gingival recession,<sup>2,3</sup> oral mucosal lesions,<sup>3,4</sup> leukoplakia,<sup>1,2,4</sup> and oral cancers.<sup>1,3,5</sup>

Despite the 11.7% reduction nationally in cigarette use among adults from 1970 to 1991, smokeless tobacco use showed little decline except among women, a group in which use of smokeless tobacco is generally uncommon. Among males, however, the prevalence of smokeless tobacco use increased during those years from 5.2% to 5.6%. The age group with the greatest increase consisted of males ages 18–24, where the rate increased from 2.2% in 1970 to 8.4% in 1991. Within this age group, snuff use increased from 0.7% to 6.2%, while chewing tobacco use rose

from 1.8% to 4.1%. Yet, for all age groups, chewing tobacco use declined slightly from 1970 to 1991 (3.9% to 3.1%), while snuff use doubled (1.5% to 3.3%). The greatest rise in snuff use was among men ages 25 to 34, showing almost a tenfold increase.<sup>6</sup>

Epidemiologic data reported for current users is often supplemented with data about former users and a third category of “ever” users, composed of both “current” and “former” users. For example, 5.3 million (2.9%) of US adults were current users of smokeless tobacco in 1991, while 4.4% reported being former users; 7.3% were ever users.<sup>7</sup>

For Kentucky and other states, the prevalence of smokeless tobacco use is derived from several surveys relying on self-report, including the National Health Interview Survey (NHIS),<sup>7</sup> the Current Population Survey,<sup>8</sup> and the Centers for Disease Control and Prevention (CDC) Behavioral Risk Factor Surveillance System (BRFSS).<sup>6</sup> Compared with persons who do not use smokeless tobacco, current users are more likely to be male,<sup>7,9</sup> have fewer years of schooling,<sup>7,10</sup> have lower household incomes,<sup>7,10</sup> be unemployed,<sup>10</sup> reside in the southern United States,<sup>7,9,10</sup> and live in rural areas.<sup>7,9</sup>

Prevalence estimates from these national surveys provide benchmarks to plan and evaluate tobacco control programs. CDC calls for a nationwide reduction in the prevalence of smokeless tobacco use in males ages 12 to 24 to no higher than 4% by the year 2000 — down from recent estimates that range from 6.6% to 8.9%.<sup>11</sup>

Kentucky has established a state-specific goal for the year 2000: “to reduce smokeless tobacco use to a prevalence of no more than 2% among Kentuckians.”<sup>12</sup> In 1988, 6.1% of adult Kentuckians used smokeless tobacco, with use by men (11.9%) far exceeding use by women (0.9%). The overall adult prevalence in 1988 represented an increase of one third from 1987’s prevalence of 4.6%.<sup>6</sup> While data to monitor smokeless tobacco

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## Smokeless Tobacco Use

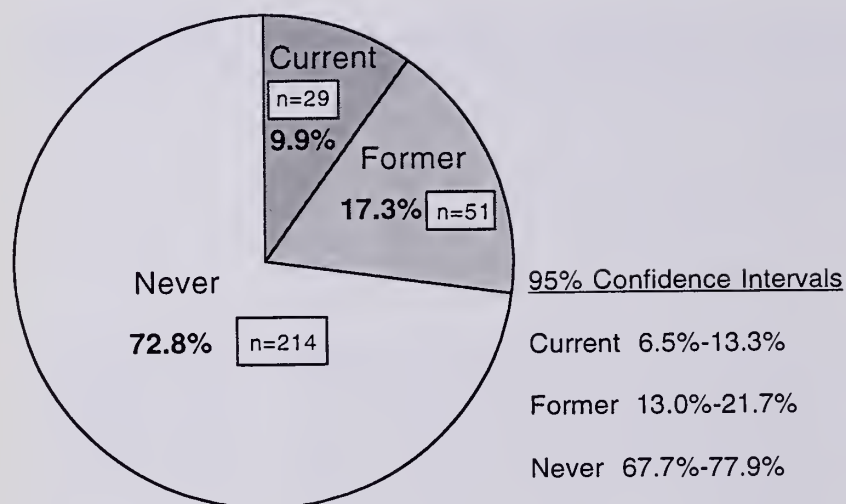


Fig 1 — Prevalence of smokeless tobacco use among males age 18 years and older, Kentucky, 1994 (n = 294).

goals have been collected in at least 24 states since 1988,<sup>6</sup> similar data for Kentucky is scant or remains unpublished. This data gap hampers the evaluation of efforts to meet Kentucky's Year 2000 goal. Since 1988, only one study on smokeless tobacco use in Kentucky has been published, and it was limited to adolescents in grades 7 through 12 in two Kentucky counties.<sup>13</sup>

Unpublished data from the CDC's Office on Smoking and Health (written communication, January 23, 1995), based on the US Census Bureau's Current Population Survey, estimated that Kentucky's overall prevalence of current smokeless tobacco use was 4.3% in early 1993, down from the same survey's 1985 estimate of 13.6%.<sup>9</sup> The prevalence among men, 8.5%, remained substantially higher than that of women, 0.5%. However, no information was available on users' age, household income, or other sociodemographic characteristics. Furthermore, these unpublished data do not differentiate between the types of tobacco products used (ie, chewing tobacco or snuff).

In an attempt to bridge the data gap on use of smokeless tobacco, we added four questions about smokeless tobacco use to an annual statewide survey. Our purpose was to estimate the prevalence of current and former users of smokeless tobacco among Kentucky adults and to compare the sociodemographic characteristics of these users with those of persons who claim never to have used smokeless tobacco.

## Methods

The Kentucky Health Survey (KHS), an annual household telephone survey of Kentucky residents sponsored by the University of Kentucky Medical Center, provided data for this study. The survey contains questions on health status, health behavior, health insurance, medical services, and sociodemographic characteristics. In 1994, four questions about smokeless tobacco were added, taken verbatim from the National Health Interview Survey (NHIS): "Have you used chewing tobacco at least 20 times in your entire life?" and "Do you use chewing tobacco now?" These two questions were repeated, substituting "snuff" for "chewing tobacco."<sup>14</sup>

In June and July 1994, trained interviewers at the University of Kentucky Survey Research Center telephoned households statewide via random digit dialing.<sup>15</sup> One adult (age 18 or older) in each household was asked to complete the questionnaire if he or she spoke English, was capable of hearing and speaking effectively on the phone, and was judged by the interviewer to be competent to participate in the survey. After an eligible respondent's consent was obtained, the interview began and lasted approximately 18 minutes. Responses to all questions were entered immediately into a computer-assisted telephone interview system (CATI).<sup>16</sup> Afterwards, data were analyzed by a mainframe computer using SAS software.<sup>17</sup>

Initially, we calculated the percentage of respondents who fell into each of four classifications based on NHIS categories of smokeless tobacco use: (1) *current* users claimed to have used snuff or chewing tobacco at least 20 times and reported using it at the time of the interview; (2) *former* users reported having used snuff or chewing tobacco at least 20 times in their lives but were not using either at the time of the interview; (3) *never* users had used smokeless tobacco fewer than 20 times in their lifetimes; and (4) *ever* users included all current and former users. We then stratified each category according to sociodemographic variables such as age group, marital status, and gender.

## Results

Interviewers contacted 1183 eligible adults; of these, 649 persons completed the survey, for a response rate of 54.9%. All respondents, who lived in 89 of the Commonwealth's 120 counties, an-

**Table 1.** Prevalence of smokeless tobacco use among Kentucky males by sociodemographic characteristics

Characteristic	Current (n = 29)		Former (n = 51)		Ever*Users (n = 80)		Never Users (n = 214)		Total (n = 294)	
Age group (years)	n	%	n	%	n	%	n	%	n	%
18-24	2	6.9	5	9.8	7	8.8	10	4.7	17	5.8
25-34	6	20.7	14	27.4	20	25.0	38	17.8	58	19.7
35-44	7	24.1	13	25.5	20	25.0	60	28.0	80	27.2
45-54	7	24.1	6	11.8	13	16.2	44	20.5	57	19.4
55-64	2	6.9	7	13.7	9	11.2	32	15.0	41	13.9
≥65	5	17.2	6	11.8	11	13.8	30	14.0	41	13.9
Married?										
Yes	23	79.3	39	76.5	62	77.5	150	70.1	212	72.1
No	6	20.7	12	23.5	18	22.5	64	29.9	82	27.9
Education (years)										
<12	7	24.1	10	19.6	17	21.2	30	14.0	47	16.0
≥12	22	75.9	41	80.4	63	78.8	184	86.0	247	84.0
County of Residence										
Metropolitan	5	17.2	13	25.5	18	22.5	104	48.6	122	41.5
Nonmetropolitan	24	82.8	38	74.5	62	77.5	110	51.4	172	58.5
Region of State										
Appalachian	12	41.4	13	25.5	25	31.2	54	25.2	79	26.9
Non-Appalachian	17	58.6	38	74.5	55	68.8	160	74.8	215	73.1
Employed?										
Yes	23	79.3	37	72.5	60	75.0	160	74.8	220	74.8
No	6	20.7	14	27.5	20	25.0	54	25.2	74	25.2
Has personal physician?										
Yes	27	93.1	45	88.2	72	90.0	178	83.2	250	85.0
No	2	6.9	6	11.8	8	10.0	36	16.8	44	15.0
Has health insurance?										
Yes	28	96.6	43	84.3	71	88.8	190	88.8	261	88.8
No	1	3.4	8	15.7	9	11.3	24	11.2	33	11.2
Household income/year**										
<\$12,500	1	3.7	6	12.7	7	9.5	25	11.4	32	11.6
\$12,500-\$24,999	5	18.5	9	19.2	14	18.9	51	25.4	65	23.6
\$25,000-\$39,999	10	37.0	13	27.7	23	31.0	42	20.9	65	23.6
≥\$40,000	11	40.8	19	40.4	30	40.6	83	41.3	113	41.1

Some columns may not sum to 100% due to rounding.

\* Ever = current + former.

\*\* 19 respondents did not answer income question.

swered the four questions about smokeless tobacco.

### Characteristics of the sample

Women comprised 54.7% of those interviewed and men 45.3%. The median age of women (47 years) slightly exceeded that of men (43 years). To determine whether the sample was representative of Kentucky's population, we compared it with the state's 1990 US Census.<sup>18</sup> The KHS sample was within  $\pm 3\%$  of the census figures for gender, race, marital status, employment, and annual household income. However, the percentage of adults  $\geq 25$  years of age who were high school graduates was 80.5% for the survey sample, as compared to 64.6% recorded by the census. Ex-

cept for this last comparison, the sample was indeed representative of Kentucky's population.

### Smokeless Tobacco Use

The overall prevalence of smokeless tobacco use was 4.5% (95% confidence interval = 2.9%, 6.1%). All current users were male, and with one exception, all former users were male. The remainder of the analysis, therefore, was restricted to men. Slightly over one fourth of the men were ever users of smokeless tobacco (Fig 1).

Table 1 displays nine sociodemographic characteristics of the men surveyed. The table presents characteristics of former and current users separately, and also combines these two groups to compare men who have ever used



## Smokeless Tobacco Use

smokeless tobacco to men who have never used it.

**Current users** — Compared with both former and never users, current users of smokeless tobacco were more likely to be over 45, married and employed. They were also more likely to be residents of a non-metropolitan county and to live in the Appalachian region. Current users were more likely to have health insurance, a personal physician, and annual household incomes greater than \$25,000. Current users were less likely to have finished high school than either former or never users.

**Former users** — When compared with both current and never users, former users were more likely to be younger, clustering in the age groups between 18 and 34 years. Compared with current users, former users were more likely to be high school graduates, to reside in a metropolitan county, and to have annual household incomes less than \$25,000. However, former users were less likely than never users to show these last three characteristics. Former users did not differ from never users in the proportion that were currently employed or the proportion that resided in Kentucky's Appalachian region.

**Never versus ever users** — Ever users, defined as the pooled group of current and former users, were compared with those who had never used smokeless tobacco. The never users had a higher household income than the ever users and were more likely to be over 35 years old. They were also more likely to be high school graduates and residents of a metropolitan county. Ever users were more likely than never users to be married and to reside in the Appalachian region. Ever users did not differ from the never users in the likelihood of being employed or having health insurance.

### Education and Residence

Two diverse sociodemographic groups, based on education and county of residence, were identified and contrasted by user type. Among men without a high school diploma, living in nonmetropolitan Appalachian counties, 25.0% were current users of smokeless tobacco. In contrast, only 3.9% of men with a high school diploma, living in metropolitan counties outside Appalachia, were current users — a ratio of 6.4 to 1.

### Age

The proportion of never, former, and current us-

ers of smokeless tobacco varied within the six age groupings. The age group 55-64 had the lowest proportion of current users (4.9%). The proportion of former users declined steadily from age group 18-24 (29.4%) to age group 45-54 (10.5%). The proportion of never users increased with age from 58.8% among 18- to 24-year-olds to 78.1% in the 55-64 age group.

### Use of chewing tobacco versus snuff

Among the 29 current users, 20.7% used both forms of smokeless tobacco, while 58.6% used chewing tobacco only and 20.7% used snuff only. A similar proportion of the 51 former users said they had used chewing tobacco only (56.9%), while a smaller proportion (11.8%) had used snuff only, and 31.4% had used both forms. Among both current and former users, there were overall about twice as many chewing tobacco users as snuff users.

The type of smokeless tobacco currently used differed with the respondent's age. Older persons were more likely to be current users of chewing tobacco than of snuff: 21.7% of current users of chewing tobacco were age 65 years or older, while only 8.3% of current users of snuff were of this age group. The median age of current snuff users was 40, while the median age of current chewing tobacco users was 44.

### Smokeless tobacco and cigarettes

Among the 29 current users of smokeless tobacco, 24.1% were current cigarette smokers, while 13.8% were former smokers. Of all 294 Kentucky men sampled, less than 1% currently used chewing tobacco and snuff and cigarettes.

### Discussion

This study provides the first published results in several years on the use of smokeless tobacco among Kentucky adults. Furthermore, these findings from 1994 can help evaluate progress in reducing smokeless tobacco use in Kentucky. If the Commonwealth is to meet its Year 2000 prevalence goal of 2.0%, the use of smokeless tobacco we report (4.5%) must be reduced by more than half. Based on Kentucky's 1990 population,<sup>18</sup> about 67,400 persons aged 18 years and over must cease smokeless tobacco use by the year 2000.

The overall adult prevalence of smokeless tobacco in Kentucky in 1994 (4.5%) almost matches the yet unpublished 1993 prevalence of

4.3% (CDC Office on Smoking and Health, written communication, January 23, 1995). However, when compared with the 1988 prevalence of 6.1%,<sup>6</sup> the 1994 prevalence suggests a 25% decline in current smokeless tobacco use over six years.

Among Kentucky women, current use of smokeless tobacco remains extremely low, consistent with 1988 (0.9%) and 1993 (0.5%) state findings. Among Kentucky men, current use of smokeless tobacco (9.9%) remains high, over twice the national prevalence of 4.0% (CDC Office on Smoking and Health, written communication, January 23, 1995). Yet the prevalence of smokeless tobacco use we report (9.9%) is less than the state's 1988 prevalence of 11.9%. While this suggests that use of smokeless tobacco among Kentucky males has dropped by one sixth since 1988, the combination of a low proportion of current users and a relatively small sample size limits the statistical power needed to identify a true decline. A similar issue of measurement error might account for the 1994 prevalence being slightly higher than the 1993 prevalence (8.5%).

The ratio of current chewing tobacco users to current snuff users in this study (2:1) is consistent with ratios reported for the South,<sup>9</sup> though the national ratio is about 1:1.<sup>6</sup> Our results are consistent with national data on current smokeless tobacco use in two other ways: (1) snuff users tend to be younger than chewing tobacco users;<sup>6,7,9</sup> and (2) about 1 in 4 current smokeless tobacco users is also a current cigarette smoker.<sup>7</sup>

When the sociodemographic characteristics of smokeless tobacco users in Kentucky are compared with those in national studies, both similarities and differences are detected. For example, current users in our study, when compared with never users, tended to have lower levels of education<sup>7,10</sup> and reside in a non-metropolitan county,<sup>7</sup> findings seen nationwide. However, our findings differed from national studies which reported that current users had lower incomes than never users<sup>7,10</sup> and were less likely to be employed.<sup>10</sup>

Since about 9 out of 10 current smokeless tobacco users reported having a personal physician, several implications for primary care are evident. Among the most important for physicians is patient counseling and education on cessation of smokeless tobacco use. One recent cessation program conducted in a dental office increased the proportion of users who quit by about one half.<sup>19</sup> The *Guide to Clinical Preventive Services* recommends that tobacco cessation counseling be offered on a regular basis to all patients who

use tobacco products, including smokeless tobacco. Furthermore, adolescents and young adults who do not currently use tobacco products should be advised not to start.<sup>20</sup>

The results of this cross-sectional study must be tempered against several limitations, including the variability of the overall and gender-specific prevalences, sampling biases of telephone surveys, and validity of data obtained from self-report. The confidence intervals shown in Fig 1 reveal the variability of the prevalences, given the sample size and low proportion of users in the sample. In addition, telephone surveys cannot reach persons without telephones, who are more likely than those with telephones to have a lower income, to live in a rural nonfarm area, and to have less education.<sup>16</sup> Since these same factors are also associated with current use of smokeless tobacco, the prevalence of current users might have been higher if persons without telephones had been surveyed. This might also explain the higher education level in the sample compared with the 1990 census. Lastly, data obtained from self-report regarding behavioral risk factors, such as alcohol and seat belt use, may not be predictive of actual behavior.<sup>21</sup> Since the use of smokeless tobacco is often seen as socially undesirable, some current users might have denied being users.

Researchers may wish to replicate this study using a larger sample size. Our decision to add questions to an existing fixed-sample survey, though highly cost-effective, limited statistical power needed to detect statistical significance, particularly for changes in smokeless tobacco use since 1988. One solution to the problem of low sample size would be for the Kentucky Department of Health Services to add questions on smokeless tobacco use to future versions of the BRFSS survey, which annually samples about 2000 persons statewide. Furthermore, questions could be added regarding patterns of smokeless tobacco use, such as cumulative years of use, frequency of use, attempts to quit, involvement in tobacco production, and age of first use.

In summary, persons most likely to use smokeless tobacco in Kentucky are those who have not completed high school, who reside in non-metropolitan counties, and who live in Appalachia. Given the increasing popularity of smokeless tobacco nationwide, particularly among young males, prevention efforts must be escalated in order to reach Kentucky's Year 2000 goal of a prevalence of no more than 2%.



## Smokeless Tobacco Use

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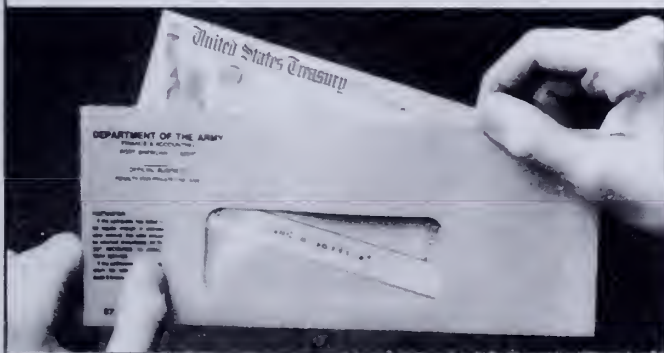
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# Danny M. Clark, MD

## KMA President 1995-96

**RX** — An ob/gyn practice in a small town in Kentucky: q.d., for happiness.

Danny M. Clark, MD, this dedicated and committed physician who has risen to the top of the medical community in Kentucky, just might write this prescription for many young medical graduates seeking happiness and contentment in their practice.

Following a circuitous and interesting route through Los Angeles, Michigan, and the Air Force, Dr Clark filled this prescription and returned to the area of his roots and the people who so greatly influenced his decision to become a physician — and an atmosphere where his patients have also become his friends.

"I grew up in a small town, Paris, close to Lexington. We lived most of my youth in a house right at the edge of downtown. I began delivering newspapers when I was ten and then spent several summers working on a racehorse farm. That was high paying work — 50 cents an hour. Following graduation from Bourbon County High School, I attended Transylvania University in Lexington and worked for a supermarket. The summer before my senior year of college, I married my wife, Joyce.

"My decision to go to medical school was primarily because of our family physician in Paris, Dr Rickman.

He was a fine figure to me. So after I earned my undergraduate degree in 1958, Joyce and I moved to Cincinnati, where I completed my medical degree in 1962.

It was during his internship that Dr Clark's chosen specialty, obstetrics and gynecology, evolved. "We went to Los Angeles County Hospital to intern because it paid more than most of the general hospitals — \$195 a month. I began my internship in LA under jail ward, which is exactly that — a jail with about 100 inmates with various medical problems. After three weeks, I went from what was the low point of my internship to something I thought was just wonderful — delivering babies. My specialty had been decided. To me, there's just nothing like obstetrics. Each birth is truly a miracle.

"Following internship, I spent two years in the Air Force in Michigan working in the oldest hospital the Air Force had at that time. It was interesting. There was a 15 patient female bed ward, a 15 patient male ward, and a 10 bed obstetrical ward. The obstetrics ward was one big room with 10 beds around it, and if you wanted to eat you went to the table in the center of the room. You had to go to the nursery to pick up your baby. It was a little different."

While still in the Air Force and looking for a place to practice, Dr

Clark returned to Kentucky. Enroute from Harlan to Elizabethtown, he stopped in Somerset to spend the night. "I thumbed through the yellow pages and discovered there was an obstetrician in town, so back in Michigan, I decided to give him a call. To my surprise he was looking for a partner. . . .and the rest is history. We've been in Somerset since 1969.

So two areas not particularly high on most graduates' priority lists, obstetrics and small town practice, have been richly rewarding for this dedicated physician. He has never regretted either decision, *and he is contented and happy.*

### The Ascent to Leadership

**P**racticing medicine in a small town has in no way diminished Dr Clark's effectiveness and clout in the professional realm. Even though he did not seek top leadership, his peers sought him. "I had served two terms as Trustee and came to Louisville for what I thought was my last Board of Trustees meeting, without an inkling that I would have anything to do in the future. I left as a member of the Licensure Board, the Board of Directors of the Insurance company, and Vice Speaker of the House! When I was elected Vice Speaker in a contested election, I realized that perhaps my peers



thought I had some abilities, and there might be a future for me in leadership. It was a very satisfying night for me when I was elected Vice-Speaker."

A strong, vibrant, vigorous, competitive, and proactive Kentucky Medical Association must be perpetuated, and Dr Clark is well grounded with a unique all-around perspective on the challenges that come with the mantle of presidential leadership. His service on the Board of Medical Licensure, the Kentucky Medical Insurance Company board, as a Delegate for several years, as a Trustee for 6 years, terms as Vice Speaker, Speaker, and President-Elect, and too many committees to enumerate have prepared him to deal effectively with his leadership role.

Many comments indicate that Dr Clark will be reluctant to take personal credit for accomplishments during his term. He wants everyone in the organization to be positive, to be empowered. "Leadership is a matter of uniting people to accomplish an agenda. Leadership is not saying this is my idea, this is what we are going to do, and now you do it. We have been very fortunate, at least in the 25 years that I've been involved, that KMA Presidents worked by achieving agreement on issues rather than by executive fiat.

"I'm amazed by the diversity among physicians, and yet having these diverse feelings about many subjects, their ability to work together for the common good. I've seen many significant disagreements at KMA's Board of Trustees over the years, and yet when it was all over, we had reached a consensus for the good of medicine."

He continued, "There obviously is enough work to go around, to be delegated. One of the marks of good leadership is the recruitment and training of leaders for the future. We must get more young physicians involved on the Board of Trustees,

our committees, and other functions in which we participate. The more you give people to do, the better leaders they become. KMA is encouraging more women physicians to become involved. We have a number who are very active, but not nearly as many as we would like."

While discussing his introduction to organized medicine, Dr Clark provided a brief glimpse of a personal side that is seldom seen. He is all business when conducting Association affairs and as he moves hurriedly from point to point, but when he discusses those near and dear to him, his demeanor softens and he reveals compassion and vulnerability. It was with an emotion-filled voice that he spoke of his departed friend, former KMA Board Chair Bob McLeod.

"Bob introduced me to organized medicine. I had been in Somerset a year or so when he told me I needed to come to the KMA meeting as a Delegate. People who knew Bob will understand that there wasn't anyway you could say no to Bob McLeod. When it comes to organized medicine, the most satisfying moment in my career was the day that Bob McLeod received his award as the outstanding physician. This meant a great deal to me."

### The Patient's Advocate

**D**r Clark has taken on the ultimate commitment in statewide organized medicine, the presidency of the Kentucky Medical Association, with enthusiasm, conviction, and a "primary goal to continue to improve the quality and availability of health care to the citizens of the Commonwealth and to further the aims of the organization's health."

He also has a compelling, driving goal to personally do all he can to restore something of utmost importance to him — the physician-

patient relationship. He has rendered compassionate care to patients in the small town of Somerset for more than 26 years, and until recent years could focus solely on caring for and attending to the well-being of his patients.

"I remember it, I loved it — it's gone." Dr Clark lamented the days when physicians had complete autonomy. The liability situation, government regulation, and interference in the daily lives of physicians has been stifling. The pendulum has swung too far and organized medicine is striving to return the pendulum to mid-point. Dr Clark thinks it will.

"Managed care has had perhaps the most dramatic effect upon health care. We have long, established patient-physician relationships that have been broken up by employers and third party payors. Physicians are losing patients and patients are being forced to leave doctors they have had for many years because of insurance.

"Denying authorization for procedures or hospital stays really puts all the legal onus on the physician. Insurance companies are careful not to tell you that you can't do a procedure or you have to send someone home from the hospital. They simply say they won't pay, and since the patient can't afford to pay, they go home. But if the prematurely discharged patient gets sick, they look to the physician and not the third party payor. An anonymous voice on the telephone should not be telling us how to care for our patients. At the very least there should be some face-to-face encounter between the physician and his patient that decides whether or not care is necessary. But that's wishful thinking."

Until organized medicine can reverse current political trends that threaten physician autonomy and patient choice, Dr Clark believes managed care organizations will continue to focus on the financial



*Dr Danny M. Clark's family proudly shared in his inauguration as the Kentucky Medical Association's 145th President. Pictured L to R—daughter Joyce Ann, son Miles, wife Joyce, Dr Clark, daughter-in-law Patty, and son Mark. Sons Mike and Pat were unable to attend the inauguration.*

bottom line. "There is too much profit in medicine now going to the entrepreneurs who run managed care groups, and this is taking money away from the care of patients. Third party payors are putting cost of care ahead of quality, which is a definite negative for patients and physicians."

He wants to ensure that the absurdity of economic and regulatory incursions into the examining room are communicated to the public and the legislature. "Dealing with legislators is a year-round process — we must be in contact with them often, even when they're not in Frankfort. They must understand our thinking, and if they don't agree, then we must decide to support someone else. And we have the opportunity to communicate with our patients — we need to get them involved in their health care."

### Medicine and Politics

**D**r Clark's presidency will cover a very difficult year. The 1996 Kentucky General Assembly

might well be the most difficult KMA has undertaken. But even in today's volatile health care environment, he is optimistic. He recognizes that KMA's lobbying efforts run deep, and that by dint of considerable hard work, its lobbyists are well respected. "The legislators that I know always speak well of KMA's lobbyists as being both effective and easy to deal with because they are not abrasive. KMA faces so many challenges, and most of them start with the legislature. Most of our energy this year will be spent working with the KGA and the Governor's office. Hopefully the vast amount of time, energy, and money that has been spent in courtrooms with the Governor and Secretary will not be repeated, and we can talk with each other and resolve our problems without going to that extent."

"My idea of leadership is to use a team approach with the legislature. There is no way that I will ever know as much as Wally Montgomery, our Legislative Chair, knows about the legislature. I'm not really sure I want

to. But all of leadership will be involved in the legislative process next year. We hope to repeal the provider tax; to ensure that cuts in Medicaid are restored; to preserve the patient's choice of a physician; to push for TORT reform; and we need to control managed care. As an obstetrician, an example of managed care "mismanagement" that comes to mind is the insurance company mandating 24-hour stays for normal deliveries. Two states have passed laws saying that patients must stay 48 hours. I have not seen substantive evidence that either is right, but this is a prime example of an insurance company making a medical decision without any scientific knowledge to support the action.

"But to be successful in our legislative endeavors, we must have many more physicians and their spouses involved. Spouses must realize they have a vested interest in their spouse's welfare and the practice of medicine. Every county should have an alliance because, at least in our area, the alliance has



been most effective in dealing with legislators.”

### Organized Medicine

**T**he one constant throughout the turbulent health care changes has been organized medicine, which continues to confront myriad challenges in the months and years to come. The Kentucky Medical Association is ready to stand firm for Kentucky physicians and their patients. Dr Clark hopes to ensure that KMA participates in framing change rather than simply reacting to change crafted by others.

“Only as participants in a group can we have any real influence. Organized medicine, both on the state and national level, has the staff and the ability to keep up with all the changes in health care that no one individual possibly could and continue to practice medicine at the same time. Organized medicine can speak for physicians much more eloquently than any one physician can, and those who don't belong to organized medicine really are shortchanging themselves and their colleagues.

“Managed care should not effect organized membership, either. As physicians have to participate more and more in managed care, they will see the value of having an organization they can turn to for help. The interpretation of managed care contracts is something I'm sure attorneys have difficulty with, and I'm certainly not qualified to deal with them. But on a state and national level, we can give physicians help when dealing with managed care, and that should make them all the more anxious to be members.

“Organized medicine must show physicians they are getting something for their money. We must give more physicians an opportunity to participate in what we do — through committees, the House of Delegates. We must have physicians encouraging

other physicians to join. It's not enough for leadership to recruit, but the other members must also recruit. We need to ensure that more and more young physicians see the need for belonging to organized medicine.”

### The Profession

**T**o Doctor Clark being a physician is still an honor and a calling. “I know nothing that is more rewarding than this profession. But you really have to want to be a physician. I think I'm living proof that you don't have to be super intelligent to be one, but you have to be willing to work hard, and you and your family must be willing to make sacrifices. I feel that, number one, you must care about people and want to do things for them — to be willing to help them not only with their medical needs, but with their emotional problems. And if you cultivate this, you wind up with a practice where your patients are also your friends.”

### “Free Time”

**A**s he urges other physicians to do, Dr Clark is extensively involved in his local community. His list of professional affiliations is exhausting, yet he has found time to serve four terms as chairman of his church board; on the local school board for 8 years, a portion of that time as chairman; on the advisory committee for a nursing program at the community college; the board of his country club; and in a conservation-oriented organization called Quail Unlimited, to name a few.

An yet, when not putting in his 60 to 80 hours a week at the office, hospital, or attending meetings, Dr Clark finds time to relax. “Sitting on a tractor, playing golf, or fishing is good for stress. I don't play golf very well, so it seldom bothers me to hit bad shots, and it's something I can do on call with the help of a beeper. We

live on a 90-acre farm, and that requires a certain amount of work. I hunt a little in winter, and when I'm inside I enjoy reading and playing cards, mostly bridge and poker. I'm trying to learn blackjack, but I'm not very good.”

### His Family

**D**r Clark is a devoted family man. His wife and best friend, Joyce, is Immediate Past President of the KMA Alliance and shares his enthusiasm and hard work in organized medicine. They celebrated their 38th wedding anniversary this year. Dr Clark speaks proudly of his five children and seven grandchildren. Their only daughter, Joyce Ann, has three children, and sons Mike and Mark each have two. Sons Pat and Miles are newly married. “We have a wonderful family, and we lucked out because we've got great inlaws. The children chose well.”

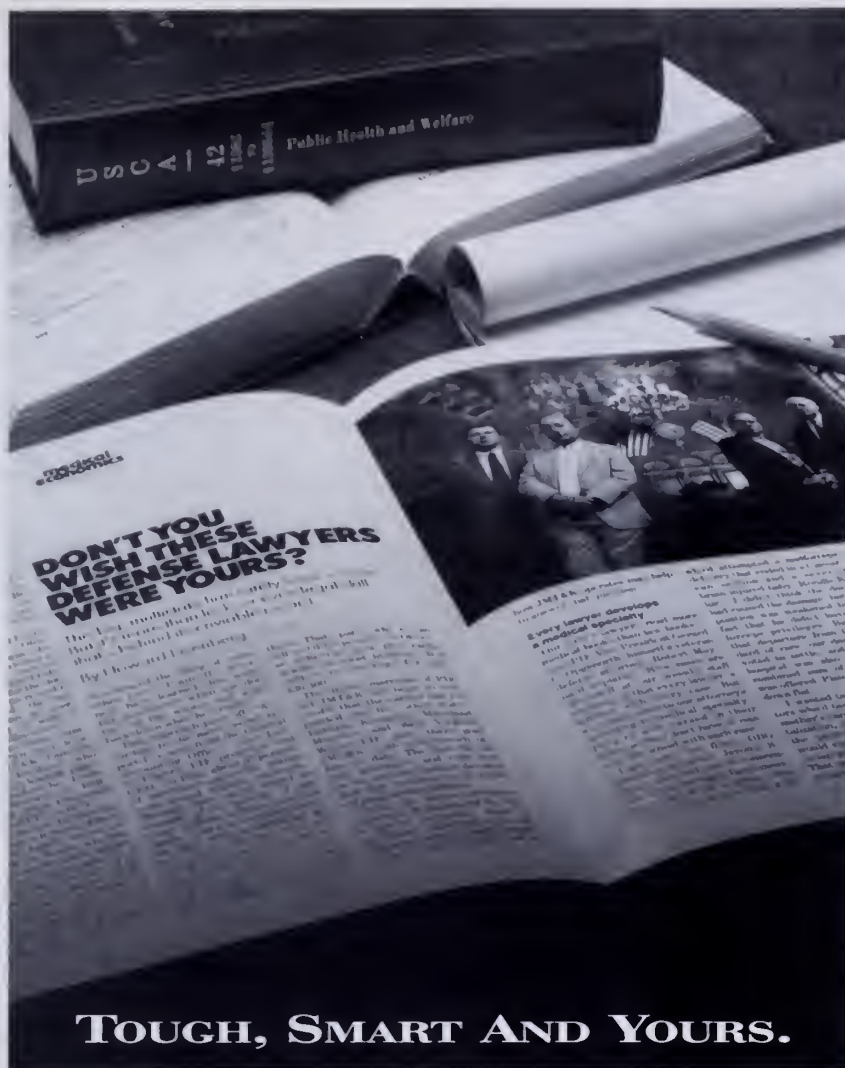
### The Presidency

**D**r Clark's efforts for health care set an example for all physicians, yet he doesn't seek grandeur in his presidency. He simply wants to do a good job.

“If we have improved the ability of our patients to get good health care — both in terms of availability and quality — and been able to preserve the patient-physician relationship, then I will be pleased with my presidency.”

When asked how he wants to be remembered as President of KMA, Dr Clark still does not seek the limelight. “As someone who was honest and caring, and who, with the help of KMA's leadership and members and staff, was able to continue the programs we had started and to continue to improve health care for our patients.”

— Sue Tharp  
Managing Editor



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MODERATED BY R. BURL McCOY

Friday, November 17, 1995, 9A.M. - 4 P.M.

Fasig - Tipton Conference Center

2400 Newtown Pike

Lexington, Ky.

Understanding fraud and abuse issues and their implications for healthcare transactions is essential, as the enforcement agencies continue to focus their efforts on the healthcare industry. This program has been designed to provide healthcare professionals, office administrators, and other healthcare executives with the critical information necessary to avoid breaches of federal and state laws governing healthcare billing and administration. The faculty is made up of private practitioners and industry experts, as well as leading federal and state enforcement officials.

## ***WHO SHOULD ATTEND:***

- \*Healthcare professionals who care for Medicare and Medicaid patients
- \*Office administrators who manage billing and financial systems
- \*Accountants or other support personnel in the healthcare system chain of financial responsibility

## ***SUBJECT AREAS WILL INCLUDE:***

- \*Healthcare and criminal law primer
- \*Fraud and abuse issues, false claims and ethics in serving patients covered by government programs
  - \*Compliance programs
- \*Pitfalls in billing, coding, and payment
  - \*Avoiding mistakes
- \*Case studies of fraud and abuse claims

## R. Burl McCoy

R. Burl McCoy is the senior partner of McCoy, Baker & West law firm, in Lexington Kentucky. He is a former assistant U.S. Attorney, and has a wealth of experience practicing in the federal court system. Mr. McCoy has served as a Special Judge on the Supreme Court of Kentucky, and is an adjunct professor of law at the University of Kentucky, where he teaches litigation skills. He is recognized in the publication *The Best Lawyers in America* as one of the country's leading defense attorneys. He is a member of the Kentucky, Florida, and American Bar Associations, Association of Trial Lawyers of America, the Kentucky Academy of Trial Lawyers, the National Association of Defense Lawyers, the Kentucky Association of Criminal Defense Lawyers, and the National Health Lawyers Association. Mr. McCoy is a master of the bench at the Henry Clay American Inns of Court, and lectures on trial practice in state and federal courts. Mr. McCoy frequently defends healthcare fraud cases at both state and federal levels.



### TO REGISTER:

Please remit payment and completed registration form by mail to:

Kentucky Healthcare Law Associates  
Suite 304

410 West Vine Street  
Lexington, KY 40507

or, fax with credit card information to 606/ 233-9234

**Cancellations or Substitutions:** Cancellations must be received in writing no later than November 10, 1995. Registration fees, less a \$95 administrative fee, will be refunded following the program. If you wish to send a substitute, please call 606/ 233-9234 during normal office hours. There is no charge for substitutions.

**Please note:** Attendance is limited, and will be filled on a first come first-come , first-served basis.

## REGISTRATION INFORMATION

NAME \_\_\_\_\_

TITLE \_\_\_\_\_

ORGANIZATION \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

TELEPHONE \_\_\_\_\_ FAX \_\_\_\_\_

Please indicate if you are \_\_\_\_ physician \_\_\_\_ office administrator

\_\_\_\_ accountant \_\_\_\_ other ( please specify )

Tuition: \_\_\_\_ before November 1, 1995 \$495.00

\_\_\_\_ after November 1, 1995 \$550.00

\_\_\_\_ Check enclosed

\_\_\_\_ Credit card ( circle one ) VISA MASTERCARD

Card Number \_\_\_\_\_ exp. date \_\_\_\_\_

Name of card holder \_\_\_\_\_

Signature \_\_\_\_\_

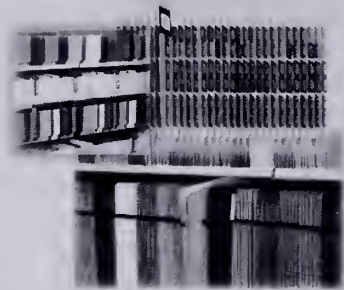
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Carl Cooper, Jr, MD  
(Photo 1994)

## "Inroads"

ONE of the more popular topics encountered during conversations with fellow physicians is the problem of "inroads" into the practice of medicine. Practically every specialty has, or soon will have, a confrontation with health groups seeking the right to practice medicine. Over the years of my experience with the General Assembly, we have encountered nurses, podiatrists, psychologists, pharmacists, physician assistants, physical therapists, optometrists, chiropractors, x-ray and lab technicians, all seeking a piece of the MD action.

Physicians generally agree that persons practicing the art of medicine should attend and graduate from medical schools. Additionally, most of us agree that the above-mentioned professionals have limited training and should be restricted to those activities for which they were trained. Ironically, physicians created most of the above-named groups to assist in areas which did not require the full attention of the physician once he made a diagnosis and treatment was begun.

With the support of bureaucrats, misinformed politicians and the benign neglect of many physicians, health groups utilizing grass roots politics have turned the medical-

health world upside down. These groups have bypassed the historical prerequisites of education, training and experience and have attempted, through legislative fiat, to enter the heretofore limited world of medicine. The real loser in this travesty is the general public, which perceives licensure by governmental bodies as a mark of approval guaranteeing quality of care.

Medicine as we know it is facing a crisis of immense proportions. Historically, we have been of one voice and a staunch defender of quality health care delivery. In the past 10 years we have seen the maintenance of individual interests by specialty societies to the detriment of the profession as a whole. At the same time, some physicians have ignored or refused support to an individual specialty society in legislative matters simply because the bill in question had no effect upon their specialty or practice. Anytime a section of medicine loses, it chips away at the fabric of quality care and the public becomes the real loser.

For every problem there is a solution. The solution to our discussion entitled "Inroads" is very simple. Our first step on the road to resolving this problem is to recognize and understand the laws and government by which we operate.

---

*From the Editor: Periodically The Journal reprints past commentaries we perceive to be of particular interest to our readers. Considering the 1995-96 elections and the convening of the General Assembly in 1996, the following article written in 1982 by the venerable Carl Cooper, Jr, is as timely today as the day it was written.*

---



The practice of medicine and all other professions comes under the purview, discretion and the direction of the Kentucky General Assembly. The General Assembly, made up of 138 distinct and different individuals representing all counties and cities in Kentucky, determines the scope of your practice and the freedom with which you pursue it. We have been led to believe that the right to practice medicine is sacred and removed from the political arena. *NOT SO!* The Medical Practice Act and all other Practice Acts are products of the General Assembly and operate under its jurisdiction.

Politicians, despite their grandiose statements, understand one simple reality, that being the polls. The late Senator Everett Dirksen once said, "Politicians have three major goals — Get elected; Get re-elected; Don't get mad, get even." If we are to

achieve any semblance of success in the legislative arena, we must get involved at the grass roots level. Secondly, we must operate as a team and present a united front to the legislature. If legislators and other groups perceive a split in medicine, they will quickly capitalize upon these differences to "divide and conquer." Thirdly, we must be flexible and not restrict ourselves to one point of view. Very rarely is any legislation passed in its original form. Additionally, we must recognize our representatives for what they are, politicians. Each politician has a broad constituency made up of varying interests. Each of these special-interest groups has their own "axe to grind." To paraphrase an old saying, "Good legislation is in the eye of the beholder," and if you remember this basic tenet, you know how the game is played. Finally, recognize that while KMA officers and

personnel work diligently to create a favorable impression on the entire General Assembly, individual legislators find their constituents at home, not on the KMA Board or staff. If we are to be successful, we must have your support and input and rely on each of you to make your views known to the Representative and Senator from your district.

The General Assembly convened on January 5, 1982, to consider some 1600 Bills of which 10% will relate to physicians practice. Be informed, be interested and be active with your legislator. Your support can mean the difference and can prevent "Inroads" into quality care and protect the safety and health of our people.

**Carl Cooper Jr, MD  
Chairman, State Legislative  
Activities Committee**



Marla Vieillard

## SAVE

*Campaign Against Family Violence*, which has been the impetus for medical alliances to develop more than 600 antiviolence programs nationwide since 1991. SAVE is intended to focus attention on the nationwide problem that exists everywhere—in homes, in schools, on the streets, and in the media.

Central to this program is *SAVE Today*, which will be held annually on the second Wednesday of October to emphasize violence prevention in communities nationwide. However, SAVE is a year-round program, the goal of which is to make an impact on the devastating social problem that robs so many Americans of quality living. The AMAA has developed a SAVE kit-brochure that covers everything a small to a larger Alliance needs to know to implement a SAVE program. It also covers other aspects of how the KMAA can carry over the SAVE theme into their membership, legislation, health, and AMA-ERF projects for 1995-1996. For Members-at-Large, they have included ideas that one member or a group of friends can accomplish. Ideas include how to deal with the media, getting a city proclamation against violence and declaring October 11th SAVE day, sample postcards to send TV stations in protest of violent programming, and a list of 25 other possible activities. This package is very complete. Every Alliance member, whether in an organized county or an MAL, RPMS, or MSS group, can find a project to fit their group.

I have been asked, "What will be the KMAA's statewide project?" I feel

it is best to let individual county alliances, RPMS-MSS groups, and individual MALs decide. This is not a cop-out solution. I sincerely hope every group will participate on October 11th in a manner that fits their group. We are diverse, and what seems easy for one may not be an easy task for another alliance or member to undertake.

The KMAA Vice Presidents will be incorporating this theme into their yearly goals. I don't feel that it is too much to ask that we all observe the SAVE program on October 11th and take the pledge to help "Stop America's Violence Everywhere." Violence will not disappear unless we make it happen.

The public will be encouraged to take part in *SAVE Today* by displaying SAVE stickers on their car bumpers and windows; making their neighborhoods "SAVE zones;" turning off violent media programming for the day; or helping in a nearby shelter for victims of abuse. Physicians may order SAVE stickers for distribution in their offices to let patients know that they can have a role in solving local problems related to violence.

To receive SAVE stickers for your patients or for additional information on how to be involved in *SAVE Today*, contact the American Medical Association Alliance at 1-312-464-4470.

**Marla Vieillard**  
KMAA President

*Please turn the page to sign your Pledge Against Violence.*



## Pledge Against Violence

*I pledge  
to SAVE Today  
and Stop  
America's Violence  
Everywhere.*

*I will strive  
to end this crisis  
that threatens  
the health  
of all people  
of the  
United States  
of America.*

Signed \_\_\_\_\_

Date \_\_\_\_\_

Please mail to:

Jean Wayne  
Kentucky Medical Assn  
301 N Hurstbourne Pkway  
Louisville, KY 40222-8512.



# STOP AMERICA'S VIOLENCE EVERYWHERE

The Medical Alliance  
of the American Medical Association

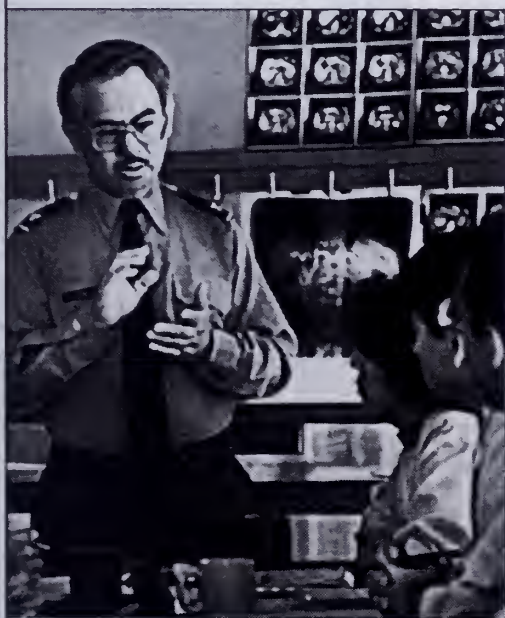
*Editor's Note: In follow-up to the September feature on "Women Physicians Leading Change," the Journal received the following contribution which was submitted past deadline.*

**T**O THE EDITOR: The rewards from care and treatment of young athletes with illnesses or musculoskeletal injuries are limitless and indescribable. These cherished memories make the more mundane aspects of medicine tolerable. Specific cases range from taking care of the elite athlete at the 1992 Olympics in Barcelona, to helping in care with the Bluegrass State Games since its inception in 1985, to talking to Little League parents or cheerleading parents about safety of their skeletally immature children. The thrill of watching a young athlete return to the sports arena following major knee reconstruction is an instant gold medal reward for the medical team. The dedication of the patient to be fully recovered and return fully to sports highlights the

advances in arthroscopic surgery which have occurred over the past decade. The science of sports medicine includes following athletes for injury and making recommendations for rule changes and safeguards to reduce risk of significant injuries. As the world elite athletes descend on Atlanta next year, sports medicine professionals focus on advancing the care and treatment of athletes in their own community, whether it be counseling on competition in the heat or programs to reduce the risk of knee injury in young female athletes or diagnosis of exercise-induced WP spasm. Focus on sports-related injuries and illness will be enhanced as the world looks in on our own Atlanta arena.

Mary Lloyd Ireland, MD

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## August Board Meeting



**Top:** KMA President-Elect Danny M. Clark, MD. **Bottom:** Secretary-Treasurer William P. VonderHaar, MD.

The Board of Trustees held its fourth meeting of the year on August 9-10, 1995, at the Holiday Inn Hurstbourne in Louisville. Reports were presented by the President, Secretary-Treasurer, Alliance President, and Senior Delegate to the AMA. In addition, presentations were made by the Dean, University of Kentucky College of Medicine; a member of the Licensure Board; Medical Director of Medicare Part B; Commissioner, Bureau for Health Services, and the President and Board Chair of the Kentucky Medical Insurance Company. A special report was presented by Beverly Gaines, MD, as a member of the Health Policy Board.

A detailed report on the Legal Trust Fund was presented and the Board voted a \$25 contribution be included on the 1995-96 dues billing statement. The current KMA policy on HB 250 was continued and nominations were forwarded to the Governor for service on the Board of Medical Licensure and the Drug Formulary Advisory Board. A number of committee actions were acted upon with recommendations from the Executive Committee, and the *Journal* editors were appointed for the years 1995-97.

The Board went into executive session to hear reports on numerous legal activities from the KMA General Counsel. Next, the Board authorized a number of resolutions to be presented to the House of Delegates with subjects of (1) Women in Medicine Month, (2) Privatization of Medicaid, (3) Medicaid Block Grant Funding, (4) Medicaid Managed Care, and (5) Insurance Coverage for Obstetrical Care. Authorization was given for

drafting additional resolutions.

Reports were then presented relating to the 1995 Annual Meeting in Lexington, computer training programs for physician offices, and workshops being planned on managed care and financial planning. A motion was also passed that KMA terminate its contract with the Ephraim McDowell Campus-Kenneth Farm, wherein KMA will no longer be responsible for the farm following the current owner's decease.

Noting that the House of Delegates last took action in 1991 to give the Board of Trustees authority in KMIC business combinations, etc, the Board voted to ask the House to again delegate authority to the Board of Trustees so the Board could act timely with respect to any proposals for the reorganization, reclassification, sale, merger, consolidation, share exchange, or other restructuring of KMIC. In 1991, the House of Delegates recognized the need for KMIC to have the flexibility to become a part of a larger group of companies, and a resolution is being introduced by the Board this year to reaffirm that concept and to provide appropriate Board authority.

The Board then reviewed all committee reports to be presented to the House of Delegates and gave recommendations on each. Some committee chairs were present to give oral reports. Actions taken to implement directives of the 1994 House of Delegates were distributed and will be made a part of the Board Chair's final report so each delegate will receive a copy.

The next meeting of the Board was scheduled for Sunday, September 17, 1995, during the Annual Meeting.



*Clockwise from top left: Beverly M. Gaines, MD, Louisville, a member of the Health Policy Board; KMA State Legislative Chairman Wally O. Montgomery, MD, Paducah; KMIC President and Board Chair Richard F. Hench, MD, Lexington; KMA President Robert R. Goodin, MD, Louisville, and Chair of the Board Donald R. Stephens, MD, Cynthiana; University of Kentucky College of Medicine Dean Emery A. Wilson, MD, Lexington; and Senior AMA Delegate Donald C. Barton, MD, Corbin.*





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## PEOPLE

**Lelan K. Woodmansee**, Jefferson County Medical Society executive director, was recently installed as president-elect of the American Association of Medical Society Executives (AAMSE) at their annual meeting in San Francisco. He has been a member of AAMSE for 18 years and has served as a board member since 1990.

An article authored by **Celestino Vega, MD**, and **Patricia Quinby, MD**, entitled "Neisseria Meningitidis — Early Treatment and Complement Deficiency, has received the 1995 Kentucky Academy of Family Physicians Paper Award. **Robert Blake, MD**, KAFP Awards Chair, made the presentation. The article was published in the June 1994 issue of the *Journal of the Kentucky Medical Association*.

**Walter H. Zukof, MD**, and his wife, **Helene**, are recipients of the first Philanthropist of the Year Award presented by the KAFP Foundation. This tribute honored "generosity, contributions of time, energy, and enthusiasm for projects."

For the second consecutive year, University of Louisville medical students have honored **Edwin E. Garr, MD**, with the Thomas B. Calhoun award. This award recognizes the teacher students feel was most outstanding during their 4 years of medical school.

**John J. Buchino, MD**, is serving as president-elect of The Society of Pediatric Pathology. Dr Buchino is Chief of Pathology, Kosair Children's Hospital, and professor of pediatrics and pathology at U of L School of Medicine.

**Joseph S. Sanfilippo, MD**, professor

of obstetrics and gynecology at the University of Louisville School of Medicine, will serve on the Board of Directors of the American Society of Reproductive Medicine. Dr Sanfilippo is also vice president of the International Federation for Pediatric Adolescent Gynecology (Federation Internationale de Gynecologie, Infantile et Juvenile [FIGIJ]).

**Stanley R. Frager, PhD**, Louisville, was one of seven recipients of Golden Rule Awards for volunteerism. J. C. Penney and Metro United Way awarded him a crystal sculpture and a \$1,000 contribution to his Boy Scout Troop 30, sponsored by The Temple in Louisville.

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## UPDATES

### KMA-Hospital Medical Staff Section Annual Meeting

The KMA Hospital Medical Staff Section will conduct its annual meeting on October 27-28 at Carter Caves State Park. The meeting is open to all HMSS members and potential members. Several crucial items will be addressed.

Following the example of the AMA-HMSS, the KMA-HMSS will consider a change in name and focus to become the Organized Medical Staff Section. This change will be discussed to focus on the needs of physicians not only in hospitals, but also in new health care delivery systems which are emerging as a result of managed care. The HMSS has traditionally worked to assure the rights of hospital-based physicians and will now look at efforts to guarantee physicians' rights in other working environments.

Other issues to be discussed at the meeting include an update and

overview of managed care and physician organizations (POs) in Kentucky, which will focus on different types of groups that have been or are being formed; the role of the medical staff in credentialing, utilization review, and quality assurance; effects on the role of the physician resulting from the passage of House Bill 250; an address of the Health Policy Board's role by one of the Board members; the development and projected use of practice parameters; and the relationship between POs and insurers.

In addition to HMSS members or potential members, the meeting is open to chiefs of medical staffs, hospital board members, and other medical staff representatives.

Reserved lodging is available at reduced rates for meeting attendees on a first-come, first-served, basis. There is no registration fee. For reservations and further information, contact the KMA office at 502/426-6200.

### National Practitioner Data Bank

The National Practitioner Data Bank (NPDB) is moving to an all electronic system, accepting inquiries only by computer modem or mailed in on computer diskettes. This change will allow the NPDB to reduce the charge for inquiries from \$4 to \$3 per name when the request is made electronically and paid by credit card or electronic transfer. However, this change in procedure will not change the way individual physicians can query the NPDB. Physicians can still inquire about their own individual record on paper at no cost.

Please call the Data Bank Help Line at 1-800/767-6732 for more information on this subject.

### Pre-Hospital DNR Forms

Pre-hospital Do Not Resuscitate (DNR)

forms authorized by the 1994 General Assembly have been developed and approved by the Kentucky Board of Medical Licensure and the Cabinet for Human Resources Emergency Medical Services Branch. These forms will authorize emergency medical responders to honor advance directives to withhold or terminate care.

This DNR form applies only to resuscitation attempts by health care providers in the pre-hospital setting (ie, patients' homes, long-term care facilities, during transport to or from a health care facility, or in other locations outside acute care hospitals). For covered persons in cardiac or respiratory arrest, resuscitative measures to be withheld include external chest compressions, intubation, defibrillation, administration of cardiac medications and artificial respiration. The DNR form does not affect the provision of other emergency medical care, including oxygen administration, suctioning, control of bleeding, administration of analgesics, and comfort care.

For more information or to obtain copies of the DNR form, contact the CHR Emergency Medical Services Branch at 502/564-8963.

### U of L Hospital Earns Highest Level of Accreditation

For the second time in a row, U of L Hospital has been "accredited with commendation" by the Joint Commission of Accreditation of Healthcare Organizations.

The Joint Commission is the nation's oldest and largest accrediting body, and the "with commendation" designation is its highest accreditation level. The hospital first achieved that level 3 years ago.

U of L Hospital is one of the few teaching facilities to achieve the Joint Commission's highest designation.

### JCMS Athletic Committee Gives Free Sports Physicals

Students from 31 Jefferson and Bullitt County High Schools got free sports physicals at JCMS Athletic Committee's Super Saturday at Bellarmine College. Committee members who are team doctors have examined their respective teams in the past few weeks. Working at Bellarmine were: **Doctors Walter Badenhause, John Mahan, John Lach, Rudy Ellis, Steven Stern, Larry Schapera, Don Pomeroy, Mark Petrik, Gil Marchal, Jeff Fadel, Greg Gleis, Bernard Speevack, Barbara Weakley-Jones, Andrew Degrusccio, Tom Laxoff, and O'tayo Lalude.**

### Robert Wood Johnson Foundation Awards Grant to The Healing Place in Louisville

The nation's largest health care philanthropy, the Robert Wood Johnson Foundation, recently announced that the Jefferson County Medical Society Outreach Program, Inc (THP) will receive a "REACH OUT" program 3-year implementation grant averaging nearly \$200,000.

In the past, The Healing Place served only men with substance abuse problems, but has recently launched a unique treatment program for homeless addicted women, bringing together volunteer community involvement and state resources. Funding from the state Cabinet for Human Resources has allowed opening of the women's recovery program.

### NEW MEMBERS

*Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.*

#### Clark

**Roi O. Reed, DO** — FP  
5810 Van Meter Rd, Winchester  
40391  
1991, WV Osteopathic

#### Hardin

**Ijaz Mahmood, MD** — HEM  
1107 Woodland Dr #105,  
Elizabethtown 42701  
1985, King Edward Pakistan

#### Jefferson

**Phillip F. Bressoud, MD** — IM  
2805 Bold Ruler Dr, Goshen 40026  
1989, U of Louisville

**Catherine P. Edwards, MD** — OBG  
6623 N Ridge Cir, Louisville 40241  
1989, U of Manitoba Canada

**Terri L. Joliet, MD** — PD  
1701 Spring St #A, Jeffersonville  
IN 47130  
1991, S Illinois U

**Robert J. Petrokubi, MD** — IM  
5129 Dixie Hwy, Louisville 40216  
1972, Johns Hopkins

**Robert R. Riedle, MD** — ORS  
7303 Willow Gate Ct, Prospect  
40059  
1984, Rush Med Coll

**Kamela Taheri, MD** — PD  
2050 Stony Brook Dr #821,  
Louisville 40220  
1976, Kabul U Afghanistan

**Karl L. Yang, MD** — CCM  
530 S Jackson St, Louisville 40202  
1984, U of Texas-San Antonio



**Northern Kentucky**

**Charles J. Breen, MD** — OPH  
2956 Wildrose Dr, Edgewood 41017  
1987, U of Kentucky

**Louis M. Lavender, MD** — OBG  
20 Medical Village Dr, Edgewood  
41017  
1982, Oral Roberts

**Radhika B. Ramesh, MD** — PD  
960 Meadowland Dr, Cincinnati OH  
45255  
1988, Madras U India

**Logan**

**Mark D. Silechnik, MD** — OBG  
108 Dale View Cir, Russellville  
42276  
1975, NY Med Coll

**Mason**

**Alfred M. Sassler, DO** — OTO  
1 River Ridge, Maysville 41056  
1983, Philadelphia Osteopathic

**Taylor**

**Kwok-Sing Cheung, MD** — PD  
101 W Beartrack Rd, Campbellsville  
42718  
1987, U Autonomado de Cd Juarez  
Mexico

**Warren**

**Ephraim D. Burk, MD** — P  
1035 Porter Pike Rd, Bowling Green  
42103  
1963, U W Ontario Canada

**In-Training****Jefferson**

**Anthony G. Karem, MD** — IM

**Northern Kentucky**

**Kylend H. Kiser, MD** — FP

**DEATHS**

**C. B. Shacklette, MD**  
Vine Grove  
1900-1995

C. B. Shacklette, MD, a retired general practitioner, died July 6, 1995. Dr Shacklette graduated from the University of Louisville School of Medicine in 1930 and was a life member of KMA.

**Robert J. Kaiser, MD**  
Louisville  
1933-1995

Robert J. Kaiser, MD, an ophthalmologist, died July 15, 1995. A 1959 graduate of Northwestern University Medical School in Chicago, Dr Kaiser was an active member of KMA.

**Morgan R. Colbert, MD**  
Louisville  
1909-1995

Morgan R. Colbert, MD, a retired orthopaedic surgeon, died July 22, 1995. Dr Colbert was a 1938 graduate of the University of Nebraska and an active member of KMA.

**Irving B. Perlstein, MD**  
Louisville  
1916-1995

Irving B. Perlstein, MD, a retired internist, died August 6, 1995. A 1939 graduate of State University of New York at Buffalo, Dr Perlstein was a life member of KMA.

**Impaired Physicians Program**  
9000 Wessex Place, Suite 305  
Louisville, KY 40222

**New Phone Number**  
502/425-7761

**New Fax Number**  
502/425-6871

**REMINDER!**

**Attend your KMA  
Pre-Legislative Seminar**

**District 1**

Oct 25 - Paducah Country Club

**District 2**

Oct 24 - Owensboro/Daviess Co  
Hospital

**District 3**

Oct 30 - Madisonville  
Trover Clinic

**District 4**

Oct 5 - Elizabethtown  
Stonehearth Restaurant

**District 5**

Oct 16 - Louisville - Jefferson  
County Medical Society

**District 6**

Oct 23 - Bowling Green  
Greenview Hospital

**District 7**

Oct 9 - Frankfort-Capital  
Plaza Holiday Inn

**District 8**

Sept 28 - Florence Holiday Inn

**District 9**

Oct 18 - Cynthiana  
Platters Restaurant

**District 10**

Oct 10 - Lexington Red Mile

**District 11**

Oct 11 - Richmond  
Pattie A. Clay Hospital

**District 12**

Oct 31 - Danville Country Club

**District 13**

Oct 19 - Ashland  
Bellefonte Country Club

**District 14**

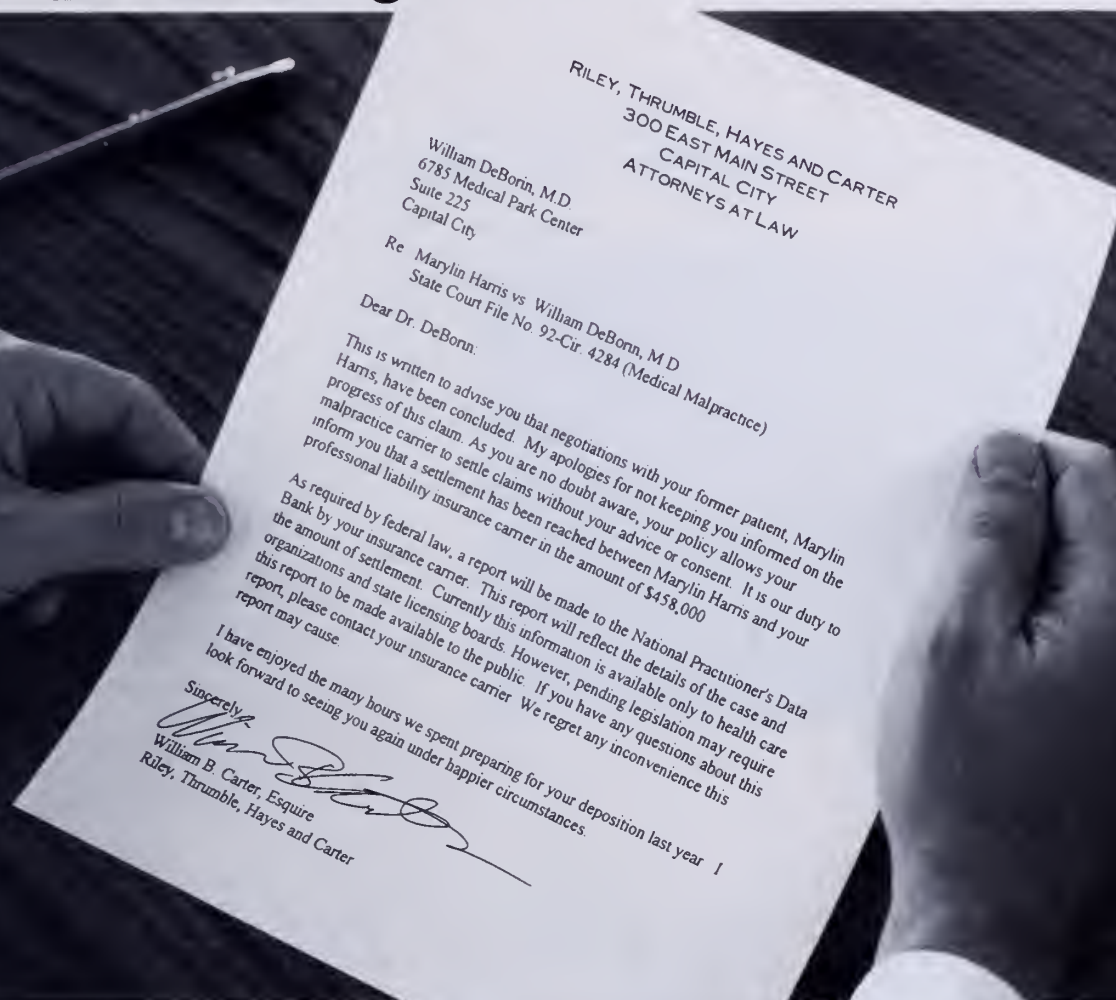
Oct 17 - Pikeville  
Green Meadows Country Club

**District 15**

Oct 12 - Corbin - Quality Inn

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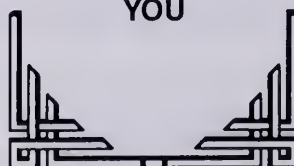
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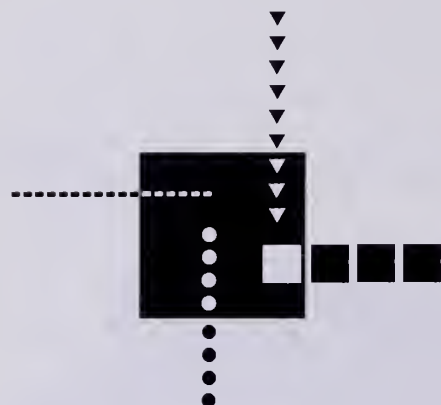
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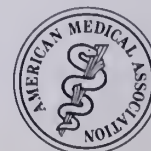
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For more information or to request an abstract submission form, call Elaine Tejcek, AMA, at 312/464-5066 or FAX your inquiry to 312/464-5841.

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**13-14 — Contemporary Management of Common Respiratory Problems, Cincinnati, OH, during the Toll Stocks Celebration. Sponsored by University of Cincinnati Medical Center. AAFP approved CME program. Contact:** Robbie Cornelison, University of Cincinnati Medical Center, PO Box 670528, Cincinnati, OH 45267-0528; phone 513/558-5391; FAX 513/558-5391.

**13 — 4th Annual Keynote Symposium: Sleep Medicine '95, Columbus Marriott North, Columbus, OH. Sponsored by Riverside Methodist Hospitals in cooperation with Sleep Medicine Research Foundation, Inc and the Ohio Sleep Medicine Institute. Category I CME credits offered. Contact:** Sleep Medicine Research Foundation, Inc; 614/792-7632.

**23-27 — 47th Annual State-of-the-Art Conference, Sheraton Seattle Hotel and Towers, Seattle, WA. Sponsored by the American College of Occupational and Environmental Medicine (ACOEM). Contact:** ACOEM, 55 W Seegers Rd, Arlington Heights, IL 60005; phone 708/228-6850; FAX 608/228-1856.

**NOVEMBER**

**2-4 — American Cancer Society National Conference on Colorectal Cancer — Chicago Marriott Hotel, Chicago, IL. Contact:** Andy Cannon, Director, Public and Provider Outreach, ACS, 1599 Clifton Road, NE, Atlanta, GA 30329-4251; phone 404/329-7606; FAX 404/329-5785

**5-10 — 26th Family Medicine and Primary Care Review — Session III, Hyatt Regency Hotel, Lexington, KY. Contact:** Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; phone 800/204-6333; FAX 606/323-2008.

**17-18 — Perinatal/Neonatal Symposium, Radisson Plozo Hotel, Lexington, KY. Contact:** Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; phone 800/204-6333; FAX 606/323-2008.

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**28-February 3 — Practical Aspects of Diagnostic Radiology/Medical Imaging, Silvertree Hotel, Snowmass Village, CO, sponsored by Vanderbilt University Medical Center. Contact:** Marilyn J. D'Asaro, Manager/Program Coordinator, Div of CME, Vanderbilt University School of Medicine, D-8211 Medical Center North, Nashville, TN 37232-2337; phone 615/322-4030.

**FEBRUARY**

**4-7 — Southeastern Surgical Congress, Hyatt, Tampa, FL. Contact:** Sec/Dir, R. P. Burns, MD, UT Coll of Med, 921 E 3rd St, Ste 400, Chattanooga, TN 37403; phone 404/607-8958.

**5-7 — Cardiovascular Conference at Snowshoe (1621), Snowshoe, W VA. Sponsored by the American College of Cardiology. Contact:** American College of Cardiology, 9111 Old Georgetown Rd, Bethesda, MD 20814-1699; phone 800/257-4739; FAX 301/897-9745.

**APRIL**

**26-May 3 — 55th Annual American Occupational Health Conference, San Antonio Convention Center, San Antonio, TX. Contact:** ACOEM, 55 W Seegers Rd, Arlington Heights, IL 60005; telephone, 708/228-6850; FAX 708/228-1856.



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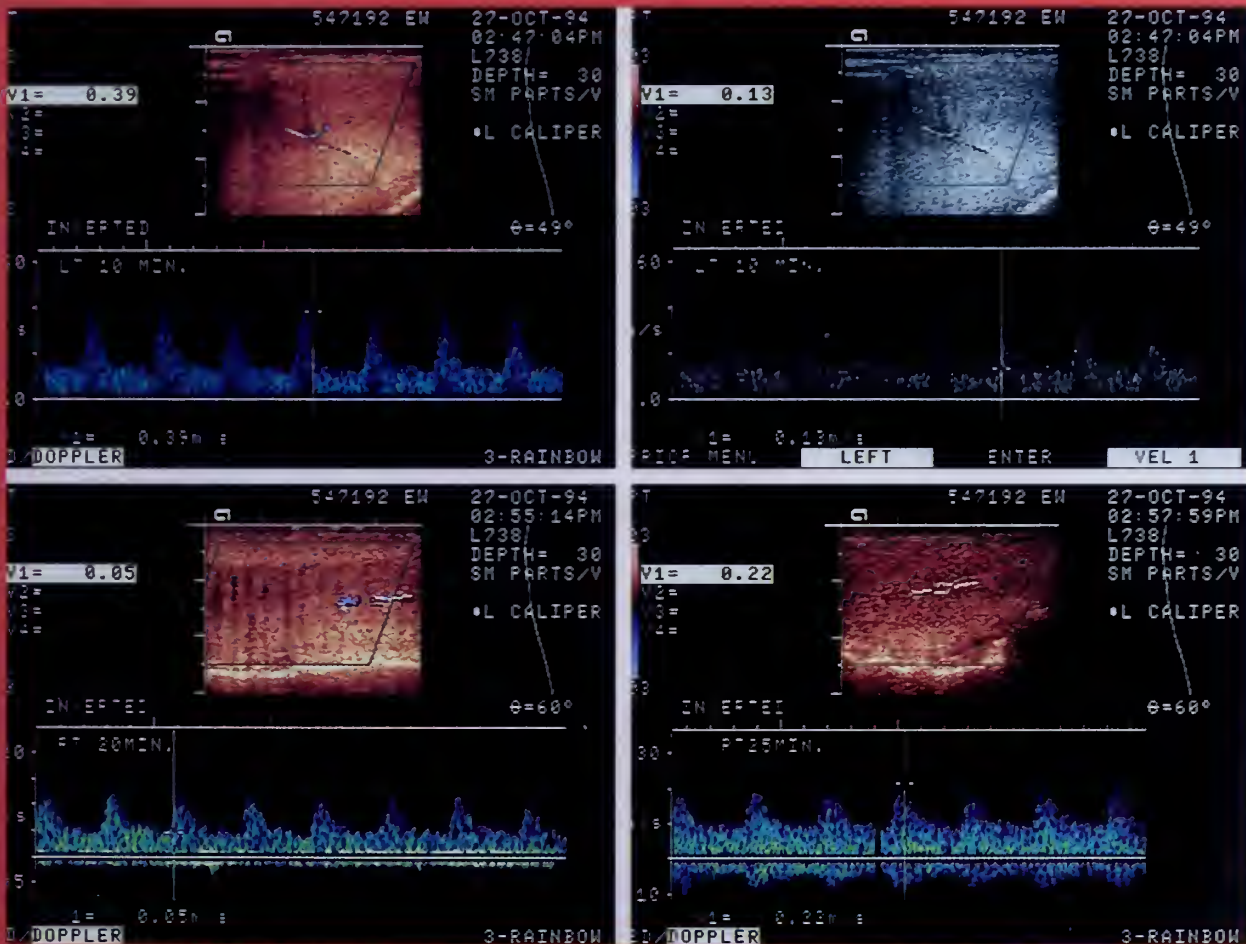
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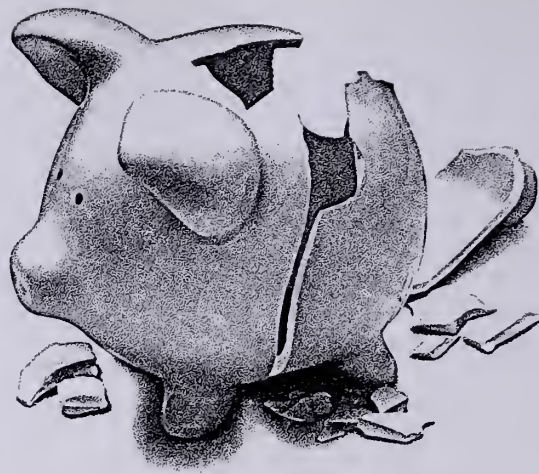
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VOLUME 93, NUMBER 11

NOVEMBER 1995

<b>COVER STORY</b>	A Goal-Oriented, Cost-Effective Approach to the Diagnosis and Treatment of Male Erectile Dysfunction <i>Robert L. Long, Jr, MD; Leonard S. Sherman, MD; Thomas J. Lombardi, MD</i>	<b>500</b>
<b>SCIENTIFIC</b>	<i>Pseudomonas pickettii</i> Pneumonia in a Diabetic Patient <i>S. Ahkee, MD; L. Srinath, MD; A. Tolentino, MD; C. Scortino, PhD; J. Ramirez, MD</i>	<b>511</b>
<b>SPECIAL ARTICLE</b>	Hazards to Children Riding in the Back of Pickup Trucks <i>Mary E. Fallat, MD; James E. Svenson, MD; Stacey S. Roussell; Vicki G. Hardwick, RN</i>	<b>515</b>
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**COVER:** Images from a duplex Doppler ultrasound examination of the penis. Doppler ultrasound is one of the latest methods for understanding the many causes of male impotence. In this issue, a Louisville urologist specializing in impotence discusses the diagnosis and treatment options for erectile dysfunction.

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## Block Grants and Medicaid

program will not fare well. If the state does not have to put up matching funds to obtain the block grants, then I suspect there will be a great temptation on the part of the legislature to use the funds they have been putting into the Medicaid program in the past in other areas of state government. We have to watch closely to make sure the state continues to use general funds for the Medicaid program.

In the 26 years I have practiced in Kentucky, it has been a continuous and ongoing struggle to secure adequate funding for the Medicaid program. The state government has always assumed the physicians would care for everyone regardless of reimbursement. With the changes in the practice of medicine, the growth of managed care, and the enlarging corporate practice of medicine, this is certainly no longer true. The burden of caring for the indigent falls on a smaller proportion of physicians than ever before. We have hundreds of thousands of patients who are uninsured and unable to afford care, especially hospital care. This is a problem that the state eventually is going to have to address, and one that they should be involved in. The recent drastic cuts in Medicaid reimbursement have caused many physicians to limit the number of Medicaid patients they will see, or to refuse Medicaid patients at all. At best, many services paid for by Medicaid in the past have been no more than a break-even proposition for physicians' offices, and it is difficult to ask physicians to see patients when reimbursement is so

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*"We have hopes that a new administration in Frankfort will be more sympathetic to the plight of Kentucky's indigent population . . ."*

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inadequate. Some physicians will see these patients, but not even bother to bill the Medicaid program because of the low rate of reimbursement.

The state has been able to find a sizeable surplus the past 2 years to fund pet projects and roads, and a good portion of this has come out of Medicaid reimbursement. It is time for them to adequately fund the care of the poor in Kentucky.

Physicians and spouses must take the time to talk to their legislators about the Medicaid program. It is also important to educate your patients about the problems with the Medicaid program as well as other changes in health care that directly affect them. We have hopes that a new administration in Frankfort will be more sympathetic to the plight of Kentucky's indigent population, but our voice must continue to be heard very clearly. We intend to keep after our legislators until these problems are resolved. With your help we will succeed.

**Danny M. Clark, MD**  
KMA President

**A**s this is written, little is certain about the direction Congress is headed. We apparently are going to have block grants for Medicaid sent to the states. In an ideal world, I suspect this could be an improvement on the present system, but in the real world, I fear Kentucky's Medicaid

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*"The state government has always assumed the physicians would care for everyone regardless of reimbursement. With the changes in the practice of medicine, the growth of managed care, and the enlarging corporate practice of medicine, this is certainly no longer true."*

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# MONITORING MEDICINE

## NEWS FOR KENTUCKY PHYSICIANS

### Talking Points Regarding Repeal of the Provider Tax

**A**s preparations for the 1996 Kentucky General Assembly begin, repeal of the physician component of the 2% provider tax remains KMA's top legislative priority. Legislators in both Houses are well aware of KMA's goal to repeal this unfair and discriminatory tax next year. While the Gubernatorial candidates and Legislators have expressed their support for KMA's efforts in this regard, the fight is far from over. In fact, it is just beginning.

Kentucky's physicians must be prepared to respond to questions on this matter from Legislators during the 1996 Session. Specifically, be ready to respond to that familiar question — if the physician component of the provider tax is repealed, what will replace it in the State's budget? Do not fall into the trap of agreeing that the tax must be replaced by another tax. Recent media accounts of the Governor's \$170 million "rainy day fund" would more than adequately replenish the State's budget if such was necessary. We must not forget that it is the responsibility of our elected Representatives and Senators to fund the budget — not ours.

Another scare tactic that KMA anticipates will be used in this battle is the argument that if the physician tax is repealed, physician Medicaid reimbursement must be reduced proportionately.

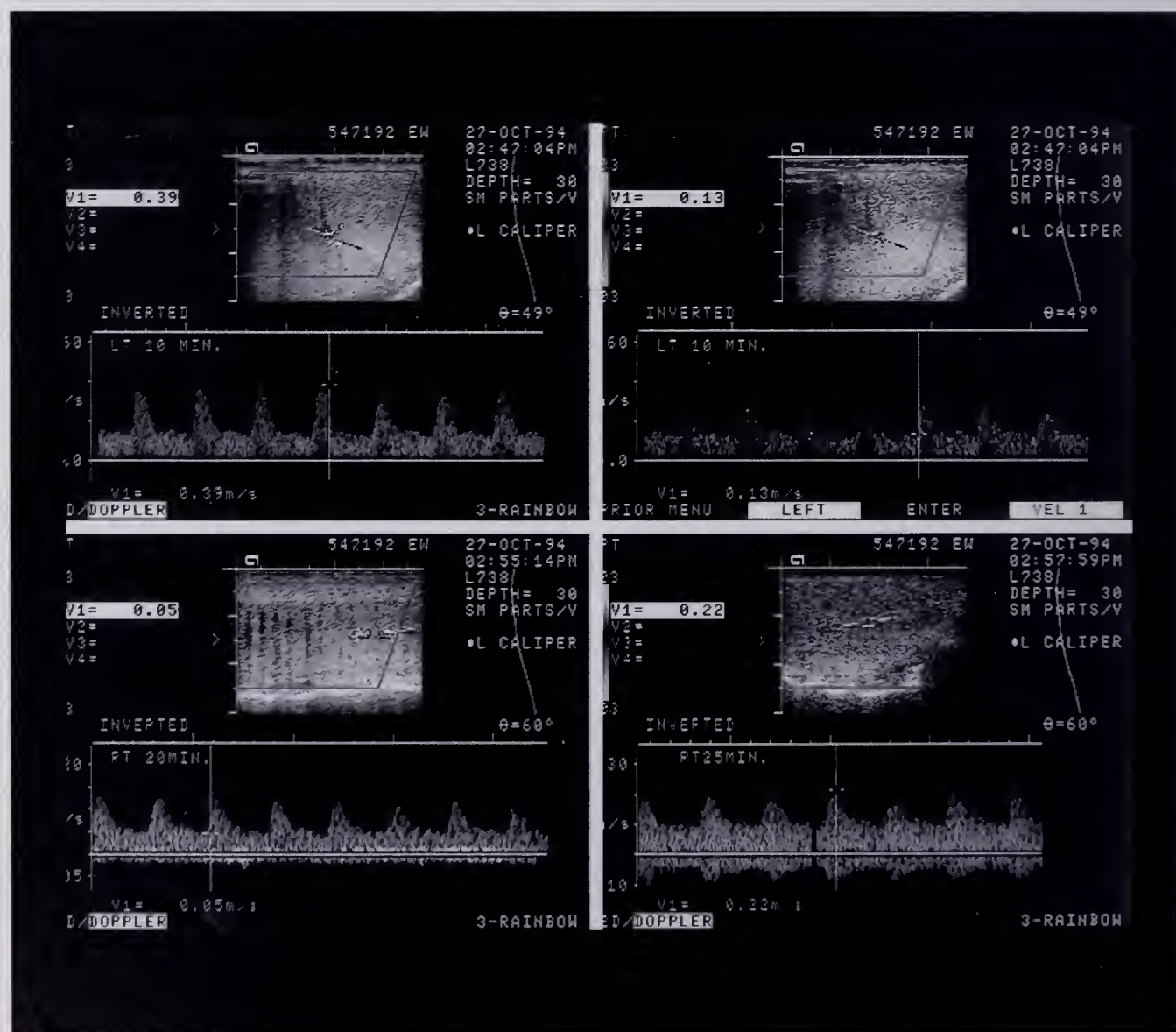
Again, nothing could be further from the truth. **There is absolutely no connection between the provider tax and physician reimbursement.** This point was hammered home on two occasions by the current Governor. First, in the summer of 1993, shortly after explaining that the Medicaid program was bankrupt and that the provider tax was the only way to keep the program solvent, the Governor took \$139 million from Medicaid to balance the State's budget. Second, in the fall of 1994, the Governor slashed physician Medicaid reimbursement by some \$52 million and again, the Governor found the previously mentioned \$170 million budget "rainy day" surplus. In short, the Governor has been utilizing the provider tax as nothing more than a general fund revenue enhancer. As such, the State's budget surplus could be utilized in this situation or, as both Gubernatorial candidates recently told KMA, there is enough savings to be had from revamping the current inefficient administration of the Medicaid program to more than adequately replace the monies from the provider tax.

In sum, be prepared to respond to your Legislators. Stand firm — insist that they vote to repeal the physician component of the tax without further reduction of physician Medicaid reimbursement.



# A Goal-Oriented, Cost-Effective Approach to the Diagnosis and Treatment of Male Erectile Dysfunction

Robert L. Long, Jr, MD; Leonard S. Sherman, MD; Thomas J. Lombardi, MD



The past 10 years are notable for marked advancements in our knowledge of the physiology of the erectile process.<sup>1-4</sup> Coinciding with these advancements are a number of diagnostic modalities that are currently being used to diagnose the cause of erectile dysfunction and for treatment options that are likely to produce a satisfactory result for both partners. At the University of Louisville, we follow a step-by-step patient-directed, goal-oriented approach<sup>5</sup> for diagnosis and treatment, which eliminates unnecessary testing and allows for cost-effective therapy. In addition, with the continuing pressure to reduce medical costs, and with capitated medical reimbursement programs, fiscal responsibility is also addressed in this approach. Tom Lue<sup>5</sup> of the University of California, San Francisco, was one of the first to advocate the goal-oriented approach for treating erectile dysfunction.

### Establishing a Goal

The goal-oriented approach begins during the first meeting with the patient (Fig 1). A reasonable goal for the desired outcome is determined by both the patient, partner, and the physician. In some cases, an extensive evaluation is necessary before deciding on the best treatment option. Whenever possible, it is strongly advised that the patient's sexual partner also be included in the diagnostic evaluation and treatment planning. Erectile dysfunction should be viewed, not as an individual problem, but as a family problem that greatly affects both partners.

### The Patient History

During the initial consultation, a patient history should be obtained to determine the extent of the patient's erectile dysfunction. Included in the history should be the duration of the patient's erectile insufficiency and exacting questions on the quality of the erection, the angle of the erection, whether or not there is curvature or pain associated with the erectile process, the frequency of intercourse, whether or not the patient is able to ejaculate (either with or without an erect penis), and whether there has been any penile or genital trauma. The patient should be asked whether he believes that he has a normal libido, or if his problem is primarily a lack of physical ability.

The patient's current medications should be carefully reviewed, and after consultation with

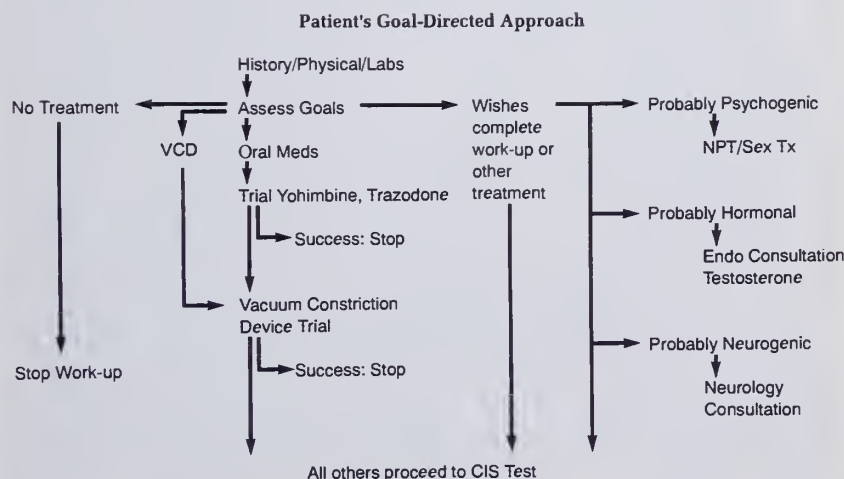
the referring physician, appropriate changes should be considered. For instance, a patient who is taking an antihistamine in conjunction with a decongestant may respond favorably by simply switching to an antihistamine alone. Most decongestants are alpha-blockers, which are detrimental to the erectile process. By discontinuing the decongestant, the patient's symptoms may resolve.

In the past, antihypertensive medications were also frequently implicated as a cause of the patient's erectile dysfunction. Based on their mechanism of action, this is not often the case with the newer antihypertensive medications. The erectile dysfunction is usually the result of long-standing hypertension, not the medication. In most cases, it is preferable to treat the patient's erectile insufficiency without altering his antihypertensive therapy, assuming that his hypertension is well controlled. If a change in his medication is made, calcium channel blockers and the alpha-blockers currently used to treat hypertension tend to have minimal negative effects on the erectile process and, in some cases, may actually facilitate an erection.<sup>6</sup>

An assessment of the patient's recreational drug, smoking, and alcohol history also is quite helpful, since recreational drugs such as cocaine and marijuana are both associated with impo-

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**Fig 1 — Algorithm for the diagnosis and treatment of impotence based on the goal-oriented approach.** Abbreviations: VCD, vacuum constriction device; NPT, nocturnal penile tumescence; CIS, combined intravenous injection and stimulation; Tx, therapy. (With permission from Brock G, Lue TF. *Impotence: a patient's goal-directed approach*. Monographs in Urology 1992;13:99-110).



## Treatment of Male Erectile Dysfunction

tency. When a patient reports erectile insufficiency and has a history of either chewing or smoking tobacco, it is usually advisable for the patient to discontinue the use of tobacco. The nicotine absorbed can produce vasoconstriction resulting in the erectile dysfunction. An occasional improvement in the erectile process has been noted with the cessation of tobacco use.<sup>6,7</sup> Long-term tobacco usage may result in permanent dysfunction secondary to damage to the endothelial cells, resulting in inadequate relaxation of the sinusoidal tissue.<sup>6,8</sup>

The overall circulation should be assessed by asking the patient about experiences with hip and leg claudication, easy fatigability, and any history of coronary artery disease or peripheral vascular disease. Blunt penile or perineal trauma may be associated with arteriogenic or venogenic impotence,<sup>9</sup> and it is not uncommon for symptoms of erectile insufficiency and coronary artery disease to coexist.

Depression is a fairly common cause of psychogenic erectile insufficiency. When this is obvious from either the history or suggested by the Minnesota Multiphasic Personality Inventory, psy-

chiatric or psychological counseling may be indicated, and improvement in the erectile process may be seen with appropriate treatment for the depression.

## The Physical Examination

During the physical examination, a general impression should be obtained with respect to the patient's overall health. He should be examined for gynecomastia, secondary sexual characteristics, anosmia, and the overall body habitus. Scrotal contents should be carefully examined for the presence of masses, cryptorchid, or atrophic testes, as well as the normal size and consistency of the testicles. Most often, when the patient's testicles are of normal size and consistency, the serum testosterone is within the normal range. If there is any concern over the size of the testicles, an orchimeter is used to gauge testicular size. However, testicle size does not necessarily correlate with erectile insufficiency, a decrease in libido, or a clinically significant decrease in the serum testosterone. During the aging process, a slow but progressive decrease in the size and the consistency of the testicles is considered normal.

The phallus should be carefully examined for evidence of strictures or plaques, evidence of meatal abnormalities, and foreskin pathology, if the patient is uncircumcised. Genital sensation, peripheral pulses, and a rectal examination should be performed. During the rectal examination, sensation, sphincteric tone, prostatic size, and presence or absence of the bulbocavernosus reflex should be noted.

## Diagnostic Techniques

After the thorough history and physical examination, a decision should be made regarding whether additional work-up will be necessary (Table 1). With the goal-oriented approach, it is advisable to review the various treatment options and work-up modalities that may be indicated at this time (Table 2).

When a patient has a history of genital trauma such as a straddle injury or direct trauma to the penis, followed by onset of erectile insufficiency, or a history of lifelong poor quality erections, then a surgically correctable lesion should be sought. The ideal candidates for evaluation and potential repair are patients who have no evidence of systemic vascular disease, are under age 50, do not smoke, are well motivated, and



Fig 2 — Spectral wave forms from a duplex Doppler sonogram in a patient with a normal response to prostaglandin  $E_1$  injection. Note high systolic velocity (>30 cm per second) indicating normal arterial inflow. Also note low end-diastolic velocity (<6 cm per second) indicating lack of significant venous leakage of blood from the cavernosum.

**Table 1.** Diagnostic Modalities.

Test	Indication
Total and free testosterone (non-protein bound); obtain in early morning; repeat if abnormal	One testicle, atrophic testicles, partial erections, decreased libido, decreased ejaculate volume, gynecomastia.
Serum prolactin	Gynecomastia, decreased total or free testosterone, recent onset of headaches or visual disturbances, and/or impotence.
Follicle stimulating hormone/luteinizing hormone	Low testosterone and/or abnormal prolactin.
Computerized tomography of skull	Elevated prolactin or hypogonadotropic hypogonadism, consider pituitary tumor.
Sleep evaluation	Sleep disorder that affects libido; evaluate rapid eye movement sleep.
Glycosylated hemoglobin	Recent onset of erectile dysfunction; evaluation of diabetic control.
Nocturnal penile tumescence monitoring	Helpful to differentiate between psychogenic and organic impotence; information regards quality of erections.
Color Doppler imaging with penile injection	Assessment of suspected impotence helps to determine possible arteriogenic, venogenic, or mixed etiology; helpful in assessing response to pharmacologic injection.
Cavernosometry/Cavernosography	Determination of corporal venogenic competence associated with erectile dysfunction. Helpful in mapping areas of venous leak.
Super selective pelvic arteriograms	Evaluation of arteriogenic impotence in an appropriate candidate for surgical revascularization.
Biothesiometry of the penis	Screening for neurogenic impotence prior to more extensive evaluation.

**Table 2.** Current Treatment Modalities for Erectile Dysfunction

Type of Treatment	Indications	Comments
Testosterone Replacement	Low testosterone	Low testosterone may be replaced via parenteral injection, scrotal patch, or oral medication. Recommended every 6 months: digital rectal examination, testing for prostate-specific antigen, and internal liver function studies for patients over 50-years-old.
Oral Therapy	Weak or partial erections	Yohimbine (5.4 mg) three times daily; trazadone (50 to 100 mg) orally every day. Not been proven effective.
Vacuum Erection Device	Erectile dysfunction, regardless of etiology	Effective for passive erections. Can be used to supplement pharmacologic penile injections. Few contraindications.
Pharmacologic Injection	Erectile dysfunction not responsive to more conservative modalities	Two most commonly used formulations are prostaglandin E <sub>1</sub> (1 to 20 mg) and triple agent, or trimix with papaverine, phentolamine, and prostaglandin E <sub>1</sub> .
Psychological Counseling	Psychogenic impotence	The urologist's role is limited and will often require counseling.
Acceptance of Status Quo	Organic or psychogenic impotence	Patient accepts current problem with erectile rigidity and is encouraged to use alternative methods for sexual fulfillment.
Deep Dorsal Vein Ligation	2° venous leak demonstrated on cavernosometry/cavernosography, age < 65, and nonsmoker	Try conservative therapy first.
Penile Revascularization	Patient age < 50, nonsmoker with demonstrable proximal (bypassable) arterial lesion	For carefully selected patients (nonsmoker, < 50 yr, bypassable lesion).
Penile Prosthesis	Organic impotence not responsive to conservative modalities	Frequently used as a "last resort."

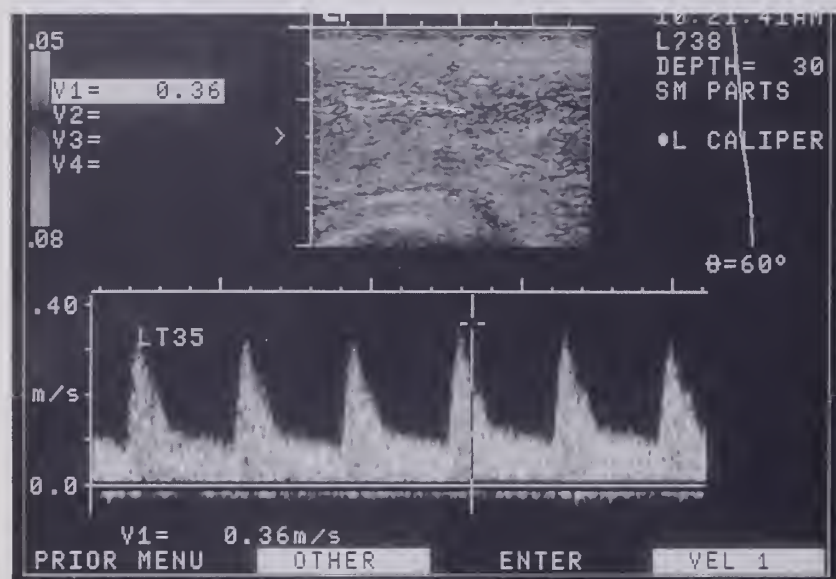
have a demonstrable lesion that can potentially be bypassed.

**Duplex Doppler imaging.** When a vascular lesion is suspected, the first test usually employed is duplex Doppler ultrasound imaging (Fig 2). Duplex Doppler imaging, in association with penile pharmacologic injection, allows the psychogenic, hormonal, and neurogenic mediators

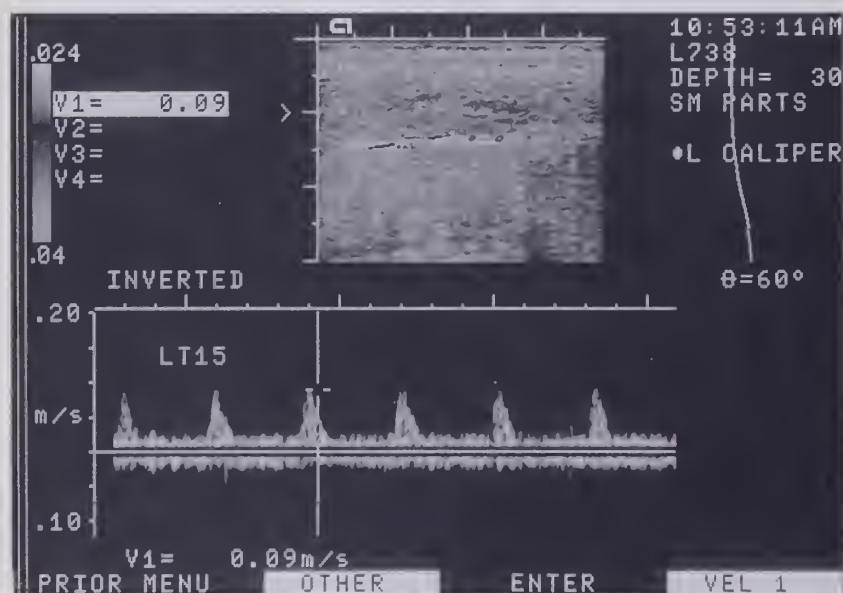
of erection to be bypassed, thereby allowing the vascular physiology of erection to be studied in isolation. Following injection, Doppler ultrasound is used to differentiate arteriogenic impotence from venogenic or mixed arteriogenic/venogenic impotence. Differentiating arteriogenic from venogenic disease is vital because the treatment regimens are quite different.



## Treatment of Male Erectile Dysfunction



**Fig 3 — Venogenic impotence.** Duplex Doppler sonogram of the left cavernosal artery following injection of prostaglandin E<sub>1</sub>. Peak systolic velocity of 36 cm per second indicates normal arterial inflow. Persistently elevated end-diastolic flow (>5 cm per second) is consistent with excessive venous leakage (ie, venogenic impotence).



**Fig 4 — Arteriogenic impotence.** Duplex Doppler sonogram of the left cavernosal artery following injection of prostaglandin E<sub>1</sub>. Peak systolic velocity remained subnormal throughout the study (9 cm per second) indicating abnormal arterial inflow. Normal end-diastolic values (<6 cm per second) indicate lack of venous leakage. Compare with Figures 2 and 3.

When performing duplex Doppler imaging studies, pharmacologic penile injections are administered with either prostaglandin E<sub>1</sub> or "triple agent" (prostaglandin E<sub>1</sub>, papaverine, phentolamine). Measurements of the corporal arteries are taken before injection and at 5-, 10-, and 15-minute intervals after pharmacologic injection. Careful measurements are made of the pre-injection corporal artery diameter, the post injection corporal artery diameter, maximum systolic flow velocities, end-diastolic velocities, and discrepancies in velocity measurements between the two corporal arteries. Also noted is the angle and the quality of the erection and whether the patient has Peyronie's plaques.

Some investigators believe that if a normal erection occurs, then significant vascular disease is unlikely.<sup>7</sup> When there is Doppler evidence of venogenic impotence (Fig 3), usually indicated by a high end-diastolic velocity (>5 cm/sec), then cavernosometry and cavernosography are indicated. When the peak systolic velocity is <25 cm per second, arteriogenic impotence is suspected (Fig 4). Super selective pelvic arteriography may be used for further evaluation of arteriogenic disease in selected patients.

**Cavernosography/cavernosometry.** If the patient's color Doppler imaging study is suggestive of venous leak resulting in erectile insufficiency, the definitive test includes cavernosography and cavernosometry. Cavernosometry/cavernosography is performed by measuring flow criterion before and after pharmacologic penile injections. This is done by constant infusion through one corpora with constant pressure measuring in the other corpora. Erection maintenance flow rates after pharmacologic injection and deterioration pressures are most helpful in suggesting a diagnosis of venogenic impotence.<sup>7,10-12</sup> If cavernosometry is suggestive of venogenic impotence, then cavernosography is the gold standard for the diagnosis of venous leak, performed by injecting isotonic contrast into one of the cavernosal bodies. This will demonstrate the area of leakage (Fig 5A and B).

**Super Selective Pelvic Arteriography.** In a patient whose history and physical examination are suggestive of potentially correctable arteriogenic impotence and whose duplex Doppler imaging study is supportive, super selective pelvic arteriography in conjunction with pharmacologic injections is considered. If the arteriogram demonstrates a bypassable lesion, the patient is given the option of a penile revascularization procedure.

## Nonoperative Treatment

After a tailored evaluation, patient/partner goals should be reassessed. Nonoperative options include the vacuum erection device, penile injection program, testosterone replacement therapy, psychologic counseling, and nonspecific medical therapy.

**Vacuum Erection Device.** The vacuum erection device, when used properly, can result in a high degree of patient satisfaction. Approximately 70% of patients, with practice and experience, report a high degree of satisfaction.<sup>12</sup> However, physicians should emphasize that partner satisfaction and participation should be a consideration when assessing treatment results.

The device consists of a hollow plastic cylinder, connecting tubing, a hand pump with pressure regulator, and an assortment of constriction bands. The constricting band is placed on the base of the cylinder, which is then placed over the flaccid penis using water soluble jelly to obtain an airtight fit. The pump is used to slowly evacuate the air from the cylinder, thus creating a vacuum and subsequently creating a passive erection. When the erection is adequate, the band is slipped from the cylinder to the base of

the penis, the vacuum is released, and the cylinder is removed. The patient is advised to remove the band after 20 to 30 minutes.

Side effects with the vacuum erection device are relatively uncommon, although bruising and ecchymosis may occur. Obviously, it is advisable to recommend that the patient remove the occluding band prior to sleep. A number of manufacturers have produced the vacuum erection devices, but most operate by the same mechanism. Success with this device may depend on the patient's manual dexterity. For this reason, certain devices may be preferable to others, and the video instructions that accompany the device should be viewed by the patient prior to the selection. In selected cases, when the erection produced by the vacuum erection device is inadequate for penetration, it may be augmented with the use of the pharmacologic penile injection program.

**Penile Injection Program.** Pharmacologic-induced erections can be created by penile injection with smooth muscle relaxants.<sup>10</sup> Appropriate candidates for penile injections may have neurogenic or vasculogenic impotence. If psychogenic impotence is suspected, nocturnal tumescence monitoring and penile pharmacologic injections



**Fig 5 — Images from a cavernosogram demonstrating venous leak (A and B). Following injection of contrast material into the cavernosum, contrast material is seen "leaking" into multiple veins (arrows).**



## Treatment of Male Erectile Dysfunction

may be helpful in differentiating psychogenic from organic impotence.<sup>7</sup> Dosages must be adjusted to the individual response.

Patients are instructed to inject the penis in the side of the shaft, below the glans using prostaglandin E<sub>1</sub> or triple agent (trimix). These injections are usually given with a 1 cc tuberculin syringe and a 27- or 30-gauge needle. Usually, 0.25 to 1 cc is used, depending on the concentration and the patient's individual response. After injection, digital pressure is placed over the injection site for approximately 30 seconds, and the medication is gently massaged into the corpora for an additional 30 to 60 seconds. Erections usually occur within 5 to 10 minutes, but should not persist for more than one hour. Erections that persist longer than 2 hours should be reversed by oral intake of either 60 mg of pseudoephedrine (Sudafed) or 5 to 10 mg of brethine. If the erection is still not reversed, then the patient should notify his physician immediately. The pharmacologic erection may then be reversed using normal saline irrigation and dilute intracorporeal injections of an alpha-agonist, such as phenylephrine. Most commonly, a combined intravenous injection and stimulation test (Fig 6) begins with prostaglandin E<sub>1</sub>, while triple agent is reserved for pa-

tients who do not respond to prostaglandin E<sub>1</sub> alone. Approximately 70% of patients achieve an adequate response with appropriate medication and dosing. However, for multiple reasons, the injection program dropout rate is about 50% (personal observations). Some patients report better quality native erections after using pharmacologic injections, or report that they use the injections less frequently than when they first began treatment.

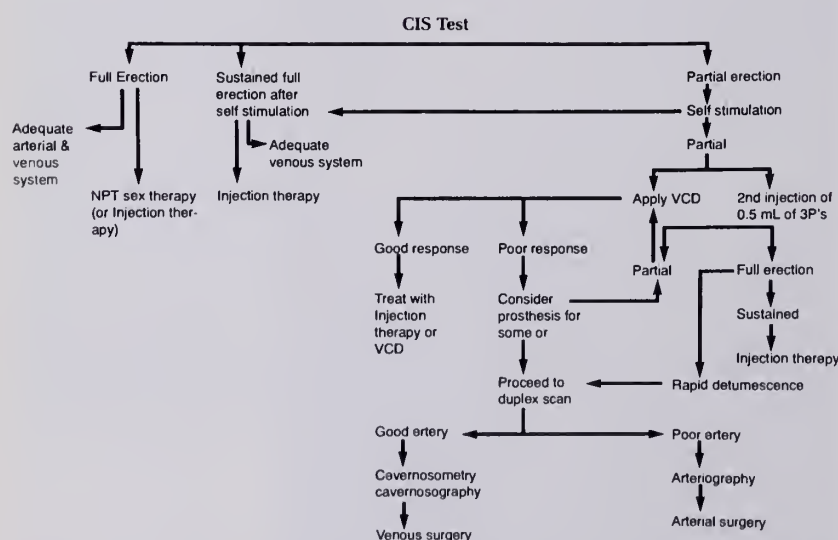
Complications include local discomfort such as burning, which is frequently associated with prostaglandin E<sub>1</sub>, occasionally a small ecchymotic area, small plaques that may form at the injection site, or the patient may have a prolonged, painful erection that will require medical intervention and reversal. If untreated, the patient may have permanent erectile dysfunction.

Patients who are started on pharmacologic injection programs should be given specific written instructions about the technique, side effects, and when to seek emergency reversal. Patients should be followed every 6 to 12 months with an examination for plaque formation. In addition, signed consent forms are highly advised, since any type of treatment for erectile insufficiency is associated with medicolegal implications. This is especially true when using medications for other than FDA-approved indications. Currently, there are no FDA-approved medications for penile pharmacologic injections, although one pharmaceutical manufacturer is expecting FDA approval for prostaglandin E<sub>1</sub>.

**Psychologic Counseling.** Although the urologist's role in treating psychogenic erectile insufficiency is usually minimal, occasionally all that is necessary is to help the patient attain realistic expectations for sexual prowess at any given age. It may be helpful to advise the patient that occasionally even happily married individuals or couples will make a decision not to be sexually active. This is not an abnormal condition requiring treatment, but simply is a lifestyle decision. If the patient and consort have made this decision, they should be supported.

For patients suffering from performance anxiety or premature ejaculation, marital sexual counseling is often helpful. Discussion regarding various techniques using sensate focus and desensitization methods are suggested. The patient may benefit from temporary or long-term use of the vacuum erection device or the penile injection program.

When the patient describes a lack of sexual



**Fig 6** — An additional work-up plan that begins with a combined intracavernous injection and stimulation test (CIS). Abbreviations: NPT, nocturnal penile tumescence; VCD, vacuum constriction device; 3P's, triple agent including papaverine, prostaglandin, and phentolamine. (With permission from Brack G, Lue TF. *Impotence: a patient's goal-directed approach*. Manographs in Urology 1992;13:99-110.)

desire, urologic treatment options are unfortunately limited. It is recommended that the patient undergo an evaluation for levels of early morning free and total testosterone and prolactin. If the testosterone studies are abnormal, they should be repeated to confirm the abnormal values, because testosterone levels will fluctuate significantly during the course of a 24-hour period. If the patient is suspected of having a prolactin-secreting tumor, appropriate evaluation involving a computed tomography scan, neurologic, or endocrine evaluation is advised.

**Testosterone Replacement Therapy.** A decrease in libido is difficult to treat unless it is associated with either primary or secondary hypogonadism. If it is associated with hypogonadism, either reversal of the cause or supplemental testosterone may be of benefit. Low testosterone levels may be seen in prolactin-secreting tumors, non-prolactin-secreting tumors, or gonadal failure. Occasionally, patients may have elevated prolactin levels with normal testosterone levels.<sup>13</sup> In those patients, treatment is aimed at reducing the prolactin level, not by increasing the serum testosterone.

When primary or gonadal hypogonadism is diagnosed, replacement testosterone therapy is indicated. Although oral testosterone tablets are available, absorption may be somewhat erratic, and the results difficult to predict. Scrotal patches with a transdermal delivery system are currently available for daily use. These patches take advantage of the increased number of testosterone receptors in the scrotal skin.

Most commonly, when testosterone replacement therapy is employed, parenteral injections are used. The dose of testosterone enanthate is usually 200 to 400 mg, intramuscularly every 2 to 4 weeks. Frequently, a once a month injection of 200 to 300 mg will demonstrate a dramatic response. When patients are on replacement testosterone therapy for any length of time, it is advisable to examine the patient every 6 months with a digital rectal examination and a test for prostate-specific antigen. Liver function should be followed every 6 to 12 months, and the patient should be asked if he has experienced any changes in urinary voiding patterns. Any changes from the baseline should be carefully evaluated. Since testosterone is an anabolic steroid, most patients report a weight gain of 5 to 10 pounds. Gynecomastia and nipple tenderness are also commonly reported.

**Nonspecific Medical Therapy.** Yohimbine hy-

drochloride (Yocon®) has been approved by the FDA as being "possibly effective in treatment of male sexual dysfunction." Yohimbine is an alpha-2 agonist. The exact mechanism of action is unknown. Many studies have attempted to document the effectiveness of Yocon®, but the effects on the erectile process are difficult to predict.<sup>8,14</sup>

Recent studies have suggested that trazodone hydrochloride (Desyrel®) has a smooth muscle relaxing effect on the corporal tissue, and this may enhance the erectile process.<sup>8</sup> If this drug is used, the patient should be made aware that the FDA does not approve the drug for the treatment of erectile dysfunction, and that it is used primarily as an anti-depressant.

## Operative Treatment

**Deep Dorsal Vein Ligation.** Patients with venogenic impotence who are not responsive to penile pharmacologic injections or the vacuum erection device are given the option of deep dorsal vein ligation. This involves ligation of deep dorsal vein and crural veins. Success or improvement rates vary from 13% to 61% after 1 year of follow-up.<sup>15</sup> Because of the less than optimal long-term success rate of the venous ligation surgery, as employed for venogenic impotence, there is ongoing research regarding the further elucidation of the mechanism of veno-occlusive (venogenic) impotence.<sup>15-17</sup>

**Penile Prosthesis.** With the advent of pharmacologic penile injection therapy, use of the vacuum erection device, and the increasing medical issues, fewer penile prostheses are being placed today as opposed to 10 years ago. The most common penile prosthesis chosen is the inflatable three-piece prosthesis, followed by the semi-rigid non-inflatable prosthesis. Informed consent should be obtained prior to any invasive procedure, and the patient should be advised that mechanical failures of penile prostheses are a common occurrence.<sup>18-24</sup>

**Penile revascularization.** Penile revascularization is an option when the patient has a potentially bypassable lesion. The inferior epigastric artery is most commonly utilized. An anastomosis is created, either with the deep dorsal vein, or to one or both of the deep dorsal arteries. Occasionally, a combination procedure using the artery and the vein is employed.

Complications of the penile revascularization procedure include: 1) hypervascularization of the glans; 2) anastomotic disruption; 3) pria-



## Treatment of Male Erectile Dysfunction

pism, arterial high flow type; 4) abdominal incisional hematoma; 5) penile edema; 6) penile hypoesthesia; 7) penile shortening as a result of scar formation.<sup>7</sup> In carefully selected patients, using strict criterion, 64% to 68% of the patients reported restoration of erectile potency at an average of 21 to 34 months.<sup>8,10,11</sup>

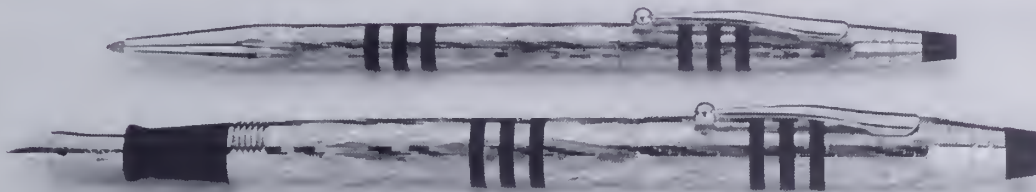
## Conclusions

Prior to any treatment planning, a candid conversation should be held with the patient and partner, and reasonable expectations should be encouraged. Although most patients can be helped to varying degrees, the actual treatment for erectile dysfunction can be frustrating for both the physician and the patient. Ideally, the obtainable treatment outcome and patient expectation should be the same. Unfortunately, this is often not the case, and this unrealistic expectation subsequently provides fertile ground for medicolegal scenarios, unhappy patients, and unhappy physicians. Any physician treating erectile dysfunction is strongly advised to emphasize realistic treatment outcomes, practice careful documentation, use written and video materials, and always obtain informed consent. In this way, a favorable outcome is more likely for both the patient and the physician.

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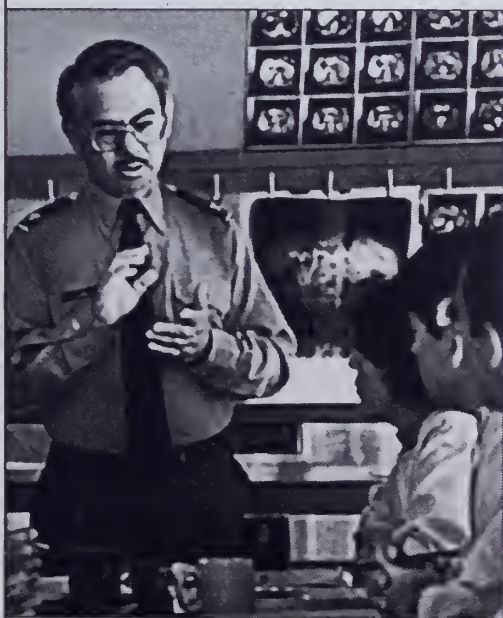
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# *Pseudomonas pickettii* Pneumonia in a Diabetic Patient

S. Ahkee, MD; L. Srinath, MD; A. Tolentino, MD; C. Scortino, PhD; J. Ramirez, MD

*Pseudomonas pickettii* is a nonfermenting gram negative rod closely related to *Pseudomonas aeruginosa* that rarely causes human disease. We describe a case of *P pickettii* pneumonia in a 41-year-old diabetic patient. Two months prior to admission, patient was treated for a methicillin resistant *Staphylococcus aureus* pneumonia. Present illness started 2 days prior to admission with fever, chills, pleuritic chest pain, and productive cough. Chest x-ray showed a right lower lobe infiltrate with effusion. Thoracentesis of the right chest brought a transudative fluid. *P pickettii* was isolated from pleural fluid and blood. The patient was initially treated with aztreonam and piperacillin and therapy was changed to ampicillin according to sensitivity results. The pneumonia resolved after 10 days of antibiotic therapy. Our case is the first reported case of *P pickettii* pneumonia. *P pickettii* has been reported to cause nosocomial bacteremias associated with contaminated intravenous products and airway colonization from contaminated respiratory therapy solution. Our patient most likely had oropharyngeal colonization with *P pickettii* during his previous hospitalization. His underlying illnesses might have predisposed him to aspiration and development of *P pickettii* pneumonia. This case emphasizes the central role of the microbiology laboratory in the proper identification and sensitivity reporting in the management of respiratory infections caused by unusual organisms, such as *P pickettii*.

**P**seudomonas pickettii is one member of the pseudomonas species, which are motile, aerobic, nonfermenting gram negative rods. Pseudomonas are classified based on ribosomal RNA homology. They vary distinctly in their ability to cause human disease (Table 1). *P pickettii* rarely causes human disease. The only reported human infections by *P pickettii* in the literature are some cases of nosocomial bacteremia associated with contaminated sterile fluids<sup>1,2</sup> and a case of vertebral osteomyelitis.<sup>3</sup> Although *P pick-*

*ettii* has been reported to cause airway colonization,<sup>4,5,6</sup> there has been no reported case of *P pickettii* pneumonia in the literature. We describe the first reported case of *P pickettii* pneumonia.

## Case Presentation

A 41-year-old male with insulin requiring diabetes mellitus, hypertension, and chronic renal failure was admitted with fever, chills, shortness of breath, pleuritic chest pain, and productive cough of 2 days' duration. Two months prior to admission, patient was treated for a methicillin resistant *Staphylococcus aureus* pneumonia. Patient presented in moderate distress with a blood pressure of 145/95 mm Hg, temperature of 100.2 F, pulse rate of 104/minute, and respiratory rate of 20/minute. Chest examination revealed de-

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**Table 1:** Classification of Pseudomonads and their ability to cause bacteremia and pneumonia.

	PNEUMONIA	BACTEREMIA
<b>RNA group I</b>		
<i>P aeruginosa</i>	+	+
<i>P fluorescens</i>	+	+
<i>P putida</i>	—	+
<i>P stutzeri</i>	—	—
<i>P alcaligenes</i>	+	—
<i>P pseudoalcaligen</i>	—	—
<b>RNA group II</b>		
<i>P mallei</i>	+	+
<i>P pseudomallei</i>	+	+
<i>P cepacia</i>	+	+
<b><i>P pickettii</i></b>	—	+
<b>RNA group III</b>		
<i>P acidovorans</i>	—	+
<i>P testosteroni</i>	—	+
<b>RNA group IV</b>		
<i>P diminuta</i>	—	—
<i>P vesicularis</i>	—	—
<b>RNA group V</b>		
<i>X maltophilia</i>	+	+



*Pseudomonas pickettii* Pneumonia**Table 2:** Generalization of antimicrobial susceptibilities against some pseudomonas species. (R:resistant, S:susceptible).

Antibiotic	<i>X maltophilia</i>	<i>P cepacia</i>	<i>P aeruginosa</i>	<i>P pickettii</i>
Chloramphenicol	S	S	R	S
TMP/SMX	S	S	R	S
Piperacillin	R	R	S	S
Gentamicin	R	R	S	S
Amikacin	R	R	S	S
Cefotaxime	R	S	R	S
Aztreonam	R	S	S	S
Imipenem	R	R	S	S
Ciprofloxacin	S	R	S	S

creased breath sounds with ronchi and dullness over the right base. Chest x-ray showed a right lower lobe infiltrate with effusion. Laboratory findings showed a white blood cell count of 7,500/mm<sup>3</sup> with 54% segmented neutrophils, 35% bands and 10% lymphocytes, hemoglobin 11.7, hematocrit 35 and platelet count 204,000/mm<sup>3</sup>. Blood chemistry showed sodium 138, potassium 3.7, chloride 101, carbon dioxide 27, glucose 216, BUN 84, and creatinine 3.4. Arterial blood gas on room air showed pH 7.44, pCO<sub>2</sub> 40, pO<sub>2</sub> 62, CO<sub>2</sub> 27 and O<sub>2</sub> sat 93%.

Sputum culture grew normal flora. Thoracentesis of the right chest brought a transudative fluid with pH 7.4, protein 2.1 mg/ml, LDH 194. *P pickettii* was isolated from pleural fluid and one blood culture. The patient was initially treated with aztreonam and piperacillin and therapy was changed to ampicillin according to sensitivity results. The pneumonia resolved after a total of 3 weeks of antibiotic therapy.

### Discussion

Our case is the first reported case of *P pickettii* pneumonia. Our patient most likely had oropharyngeal colonization with *P pickettii* during his previous hospitalization, predisposed from prior antibiotic use. His multiple underlying illnesses might have contributed to aspiration and development of *P pickettii* pneumonia. The exact pathogenetic mechanism is not totally known, but alteration of the normal oropharyngeal flora and decreased fibronectin at the cell surface have been implicated.

In contrast to *P aeruginosa*, *P pickettii* rarely causes human disease. *P pickettii* has been re-

ported in rare cases of nosocomial bacteremias associated with contaminated intravenous products. Roberts<sup>2</sup> reported 19 cases of *P pickettii* bacteremia in Australia from contaminated water for injection. Maki<sup>1</sup> had 3 cases of *P pickettii* bacteremia from contaminated Fentanyl supplies from narcotic theft by health care personnel. Raveh<sup>3</sup> reported 4 cases of blood stream infections from *P pickettii* in association with permanent indwelling intravenous devices in immunocompromised patients. Wertheim<sup>4</sup> reported a case of vertebral osteomyelitis in a debilitated patient. Nosocomial *P pickettii* airway colonization from contaminated respiratory therapy solution has been reported in a special care nursery.<sup>5,6</sup>

The *P pickettii* isolated from our patient was sensitive to betalactam, aminoglycoside, and quinolone antibiotics. The patient's initial broad spectrum regimen (aztreonam and piperacillin) was narrowed to ampicillin once the susceptibility results were known. The patient was treated with ampicillin for 2 more weeks. Narrowing the spectrum of the antibiotic therapy not only decreased the cost of therapy, but more importantly, it decreased the risk of superinfection with resistant organisms associated with broad spectrum antibiotic therapy. The pseudomonas species have distinctly variable susceptibilities from the multiresistant *P cepacia* and *X maltophilia* to the very sensitive *P pickettii* (Table 2). The microbiology laboratory plays an important role in the correct identification of the pseudomonas species, as well as giving the susceptibility results promptly so that antibiotic changes may be made accordingly.

We presented the first case of *P pickettii* pneumonia occurring in a debilitated patient with underlying illnesses. This case emphasizes the central role of the microbiology laboratory in the proper identification and sensitivity reporting in the management of respiratory infections caused by unusual organisms, such as *P pickettii*.

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# Hazards to Children Riding in the Back of Pickup Trucks

Mary E. Fallat, MD; James E. Svenson, MD; Stacey S. Roussell; Vicki G. Hardwick, RN

*Purpose:* The goal of this study was to identify the spectrum of injuries and risks associated with children riding in the back of pickup trucks and stimulate the medical and legislative community to adopt laws aimed at protective interventions for this type of travel.

*Methods:* Patients were identified and data collected retrospectively from trauma registries at the two major university urban trauma centers in Kentucky.

*Results:* From 1988 to 1993, 33 patients less than 18 years old were ejected from the back of pickup trucks. The majority were males older than 10 years. Injuries occurred predominantly during summer, in early evening, and in rural areas. Eleven patients were ejected during a collision, 19 were ejected from a moving truck, and 3 fell from a stationary truck. The head was the predominant organ injured. The average ISS score was 12.0 ( $\pm 7.5$ ). The length of stay in the hospital varied from 1 to 84 days with 13 patients requiring intensive care. Three patients died and 3 required rehabilitation therapy.

*Conclusion:* We conclude that (1) Children riding in pickup truck beds are at serious risk of being ejected from the vehicle; (2) children are frequently ejected from truck beds in noncrash events; and (3) continued attention should be directed to enacting stronger legislation limiting passenger transport in pickup truck beds.

Motor vehicle crashes are the leading cause of death and disability in children over the age of 1 year. Prevention of injury through mandatory passenger restraint laws has been enacted for most ages in all states. Over the last decade, the pickup truck has become increasingly popular for both utility and recreational purposes. However, laws that apply to automobiles regarding passenger restraint do not usually apply to pickup trucks.

Passenger transport in the back of pickup trucks is unfortunately common. Cultural and economic considerations in rural areas where this vehicle is a frequent means of transportation, often make the cargo bed a necessary passenger area. However, pickup trucks have also become popular in urban areas, predisposing to passenger travel in the truck's bed in nontraditional venues. Only a few states have addressed this issue by regulating travel in the cargo areas of trucks.<sup>1,2</sup>

Identification of unsafe behaviors by the medical community can be important in shaping safety legislation. Little information exists regarding the number of deaths and injuries to children riding in the back of pickup trucks.<sup>1,9</sup> We have reviewed our personal experience with injuries to children in the cargo beds of pickup trucks at two regional pediatric trauma referral centers in Kentucky. The goal of this study was to draw further attention to this problem in our state and stimulate the medical and legislative community to adopt laws aimed at protective interventions.

## Methods

The University of Kentucky Hospital and Kosair Children's Hospital are regional trauma referral centers serving the pediatric population of Kentucky. A trauma registry has been maintained at the University of Kentucky Hospital since 1990 and at Kosair Children's Hospital since 1988.

The trauma registries in each hospital were searched through December 1993 for patients who were riding in the bed of a pickup truck at the time of their accident. Patients older than 18 years were excluded from the analysis. Those who were riding in the cab of the truck or those in accidents involving trucks other than pickup trucks were excluded.

Data collection included patient age and sex, accident demographics such as date, time, location and mechanism, major injuries, Glasgow Coma Scale (GCS), Revised Trauma Score (RTS),

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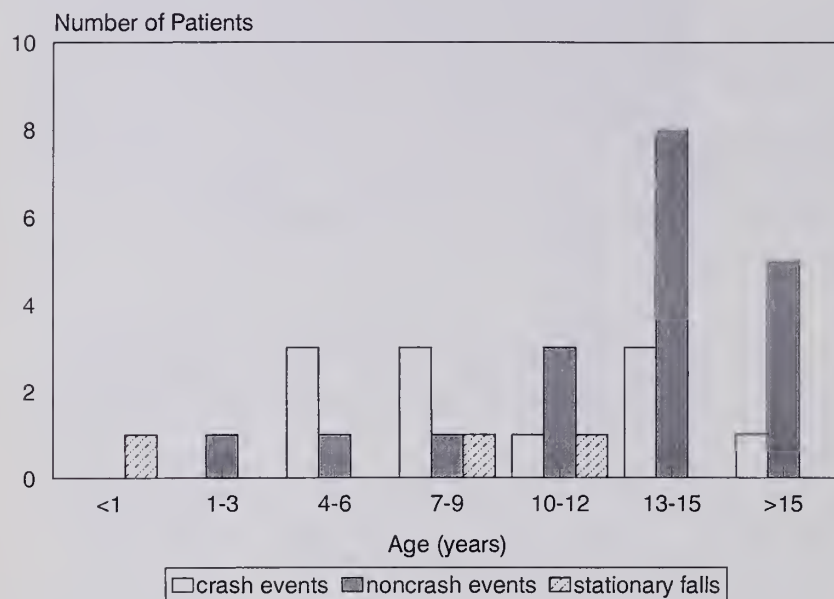


Fig 1—The age distribution of patients.

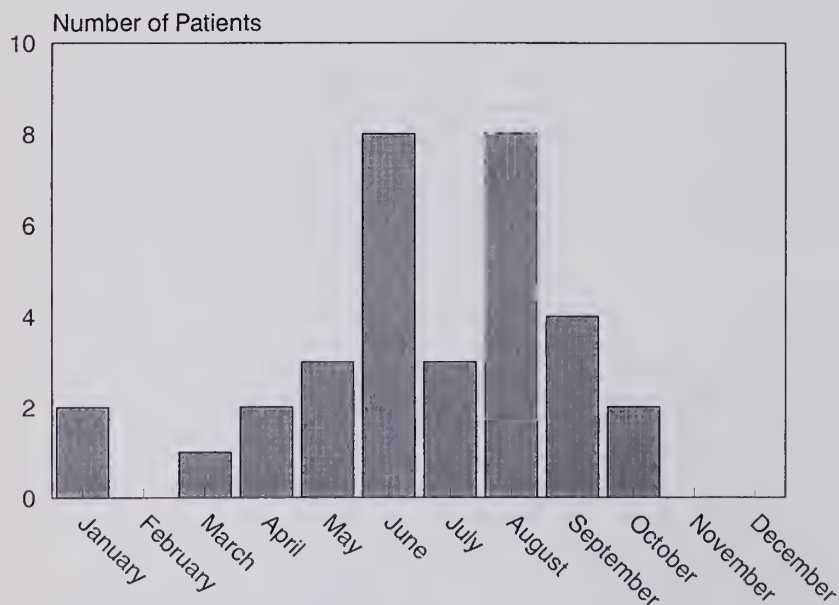


Fig 2—The months when injuries occurred.

Injury Severity Score (ISS), length of hospital stay, and discharge disposition.

Comparisons of categorical variables were carried out using Fisher's exact test. Continuous variables were compared nonparametrically with

the Wilcoxon rank sum test. All analyses were carried out using the SAS statistical software (Statistical Analysis Systems, SAS Institute, Cary, NC). A p-value of  $\leq 0.05$  was considered significant.

## Results

During the study period 1988 through 1993, 33 patients less than 18 years old were ejected from the back of pickup trucks. Eleven (33%) were ejected in crash events, 19 (58%) were ejected in noncrash events (eg, sudden stop, swerve, or fall), and 3 (9%) fell from a stationary truck. The majority were male (75%). The average patient age was 11.6 years. Most of the patients (66%) were over age 10 (Fig 1). Patients ejected in noncrash events were slightly older (mean 12.9 years) than those involved in crashes (mean 10.0 years) but the difference was not significant (Wilcoxon rank sum test  $p = 0.13$ ). Alcohol use was documented in 2 patients (serum alcohol levels were 125 and 240 mg/dl respectively).

Most crashes occurred in the warm summer months, and these occurred almost exclusively during evening hours (Figs 2, 3). Most accidents took place in rural areas (61%). Twenty-one (67%) of the victims were initially stabilized at a nontertiary hospital. There was no significant difference in ISS scores of those primarily treated at a tertiary center (10.0) versus those transferred from a non-level I hospital (12.7) (Wilcoxon rank sum test  $p = 0.53$ ).

The head was the predominantly injured area in 22 (67%) of the accidents. In the 22 patients who had predominantly head injuries, 3 had associated extremity fractures and 8 had multiple abrasions or lacerations. Of the remaining 11 patients, 6 had extremity fractures (three upper and three lower) as the predominant injury, 3 had predominantly facial injuries, and 2 had major intraabdominal injuries. Of these 11 patients, 3 were noted to have an associated minor head injury. The average ISS score was 12.0. There was no difference in severity of injury in those ejected during a crash (mean 14.0) and those ejected in noncrash events (mean 12.0) (Wilcoxon rank sum test  $p = 0.54$ ).

Thirteen children (39%) required intensive care. Eight (62%) of these stayed in the ICU 3 days or less. The average length of stay in the hospital was 7.5 days, but the overwhelming majority (82%) stayed less than 7 days. Three patients died and 3 were transferred to a rehabilitation facility after receiving acute care.

## Discussion

Pickup trucks are an increasingly popular form of transportation, both in urban and rural areas. The small size of the cab of these vehicles precludes transport of many passengers in the relative safety of the cab. When these vehicles are used for family transport or recreation, passengers often travel in the cargo bed.

This study confirms that children are at risk for serious injury or death while riding in the back of pickup trucks. All of the children in this study had significant injuries and many required intensive medical care. Ten percent of the patients died and another 10% required inpatient rehabilitation.

We have not examined the risks to children riding in the cab of a pickup truck, although travel

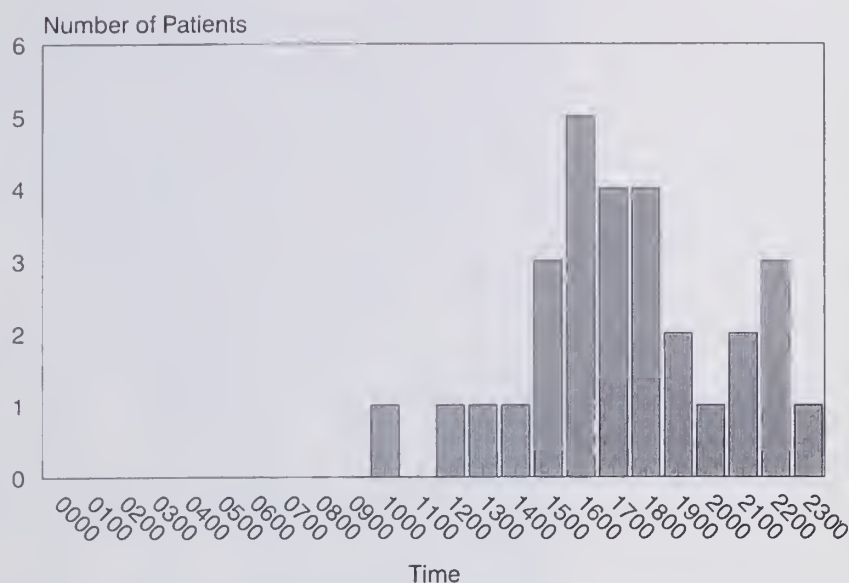


Fig 3—The time of day when injuries occurred.

Table 1: Truck Bed Legislation

STATE	CONDITIONS
CALIFORNIA	Prohibits transportation of any person in the back of a pickup or flatbed motor truck, as defined and specified
DISTRICT OF COLUMBIA	Prohibits riding in the back of pickup trucks when the driver's view is obstructed
GEORGIA	Unlawful for any person under age 18 to ride in the bed of an uncovered pickup truck
HAWAII	Unlawful for persons to stand up in the bed of a pickup truck (must sit down with tailgate closed)
KANSAS	Unlawful for children under 14 years to ride on any vehicle or upon any portion thereof not designed or intended for the use of passengers
LOUISIANA	Unlawful for children under 6 years to ride in the bed of an uncovered pickup truck
MASSACHUSETTS	Prohibits children under 12 years from riding in the bed of a pickup truck
NORTH CAROLINA	Prohibits children under 12 years from riding in the back of an open pickup bed, except under defined and specified exemptions
OHIO	Unlawful for children under 16 years to ride in the back of a pickup truck
PUERTO RICO	Unlawful for persons to ride outside the passenger cabin of a vehicle
RHODE ISLAND	Requires children to be restrained while riding in open trucks
TEXAS	Unlawful for children under 12 years to ride in the bed of a pickup truck that exceeds 35 mph

in the relative safety of an enclosed cab may not be as safe as in an automobile.<sup>10</sup> We have focused instead on cargo bed injuries, because they produce the highest risk for mortality and morbidity. Agran et al (1994)<sup>4</sup> found that passengers in the cargo area of pickups were more frequently ejected and more seriously injured than those riding in the cab. Injuries were recorded for 64% of those occupying the cargo area as opposed to 51% for those riding in the cab. However, it is not just crash events which pose a risk for children

in pickup trucks. In our study, 57% of injuries occurred due to a fall from a moving truck in a noncrash event. This is consistent with previous studies showing that injuries to children in the cargo areas of pickup trucks involve noncrash events 24% to 54% of the time.<sup>1,2,6</sup>

Since this study reflects only injuries to children who required evaluation and hospitalization at a tertiary referral center, it probably underrepresents the total number of events involving children in Kentucky. In studying injuries occurring



## Hazards to Children Riding in the Back of Pickup Trucks

in pickup truck crashes, Agran et al (1990)<sup>1</sup> found that 17% of those injured were admitted to the hospital. In addition, the average ISS score was much higher in our population; therefore, our patients probably represent a smaller, more seriously injured subset than those analyzed by Agran. Using these figures, one would predict our data to underestimate the number of crashes involving children in the beds of pickups in Kentucky by at least a factor of four or five.

At present, only a small number of states have begun to address the issue of safety for occupants in the cargo areas of pickups (Table 1). All of these laws address open pickup trucks, but many are weak statutes with numerous conditions. Kentucky has no law regulating occupancy in the cargo area of pickup trucks.

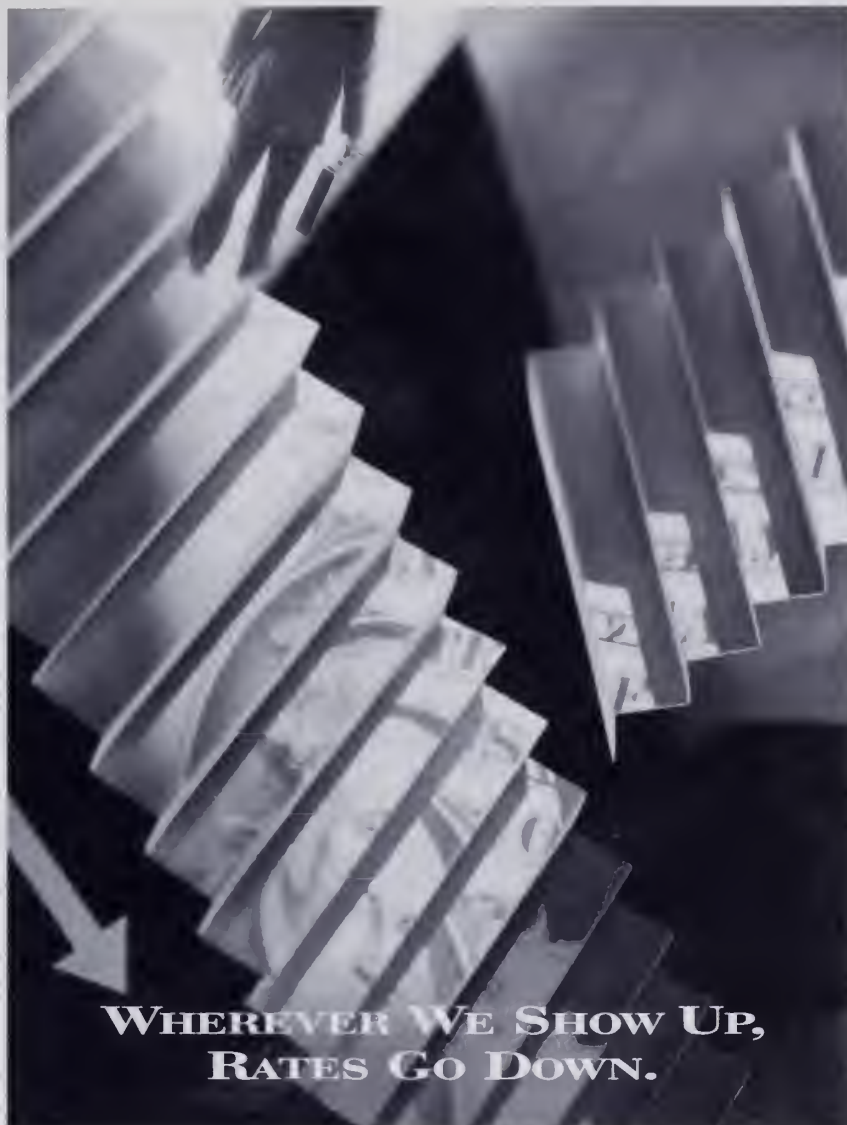
Children riding unrestrained in *closed* pickup beds, are at risk for injuries as well as from carbon monoxide poisoning.<sup>11</sup> Pickups also pose a risk to children because of their high wheel base. We noted a separate population of 14 children with 4 deaths who were struck by pickup trucks. In many of these accidents, the vehicle was in a driveway or traveling slowly and the driver did not see the child. This suggests the hazard of poor visibility from the truck cab.

This study documents the need to address preventive measures in Kentucky for children transported in the back of pickup trucks. Documenting the hazards of unrestrained travel in pickup truck beds should help convince the pub-

lic and legislators that restrictions on this mode of travel are necessary. Public policy measures aimed at eliminating passenger travel in the cargo area of pickup trucks and mandating restraints for occupants can reduce serious injuries to children in Kentucky.

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# **The Physicians of Tomorrow Mentoring Program**

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## **The Physicians of Tomorrow Mentoring Program**

- that will encourage and help Cadette and Senior Girl Scouts explore the wide range of realities and opportunities of a career in medicine.

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### **What does a Mentor do?**

- ◆ Encourage girls to continue their pursuit of a medical career.
- ◆ Serve as a resource for professional networking.
- ◆ Provide counsel on career and professional development.
- ◆ Acquaint the girl with values and culture of the work environment.

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If you are a woman physician who would be interested in volunteering as a Mentor for

### **The Physicians of Tomorrow Mentoring Program**

please contact the Kentucky AMA Chair or the Girl Scouts-Wilderness Road Council:

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#### **American Medical Association**

Donna Skinker, MD  
Department of Pathology and  
Laboratory Medicine  
Markey Cancer Center cc448  
University of Kentucky Medical Center  
800 Rose Street  
Lexington, KY 40536-0093  
(606) 323-6184

#### **Girl Scouts**

Susan V. Miller  
Program Services Director  
Girl Scouts  
Wilderness Road Council  
2277 Executive Drive  
Lexington, KY 40505  
(606) 293-2621  
1-800-475-2621

# Who Are These People?

**A**s I write this on the second of September, I can reflect back 50 years to the defining moment. I was not there, but I have seen newsreels and videos of the scene.

We are on the deck of the battleship U.S.S. Missouri and the day is slightly overcast. From every upper deck, companion way, and bridge, sailors with elbows hanging over the gunnel are peering down to this event; a momentous event.

On one side stand the general officers of the allies all in a casual line, with open shirts and multiple stars on each collar tip or shoulder boards. They have the look of scorn and contempt on their faces.

Up the gangplank and onto the deck come the emissaries of Japan dressed in silk top hats and morning coats. The chief diplomat has a painful looking limp to his gait that suggests a below hip amputation.

During the proceeding, officers of the allies and of the Axis sign the document of surrender in their respective positions on the parchment. When all have signed, the sun breaks through the overcast as General MacArthur announces, "These proceedings are closed." The war is over, and it is a wonderful day for America.

It all came about because we had dropped the atom bombs on Hiroshima and Nagasaki, and wrought a carnage of genocide. But now 50 years later there are these revisionists of history who are saying we should not have used the atomic weapons. Who are these people? How old are they? Have they ever been in harm's way? Are they alive today because

their parentage were not slaughtered on yet another beachhead in the Pacific?

Let's review the game plan in 1945 for the invasion of Japan. Operation Olympic was set for the first of November to invade the southern most Japanese island of Kyushu. US armies made up of battle tested Marine divisions and also veterans' divisions of the Army from both the Pacific and redeployed divisions from Europe were to be used. We're talking here about well over 200,000 assault troops plus the supporting elements behind them. Can you imagine the number of ships it would have taken to mount an attack like that? Can't you see the field day the Kamikaze would have had in picking out troopships or flat tops to dive into? One would have to wonder which would be the safer place — on the beachhead or out to sea?

As compared to D-Day in Normandy, there would be no "England" just several miles behind to help in the "Form-up" and for US army planes to reload and refuel for each sortie. At Kyushu our nearest marshalling area would have been Okinawa, 350 miles away. It is not too difficult to extrapolate the problems and the near failure of Overlord to the proposed nightmare of Olympic.

Remember too, that in spite of the huge largess that America had of materiel of all and every type, we were just beginning to scrape the bottom of the manpower barrel. Great Britain, Germany, and Russia had all long before reached their limits of available troops. What with our losses

already in Europe and the South Pacific another million casualties would have meant 300,000 men killed in action or died of wounds. Did we have enough for that kind of a ground victory?

Have these revisionists spent even an hour on a beachhead with machine gun fire, mines, and concertina wire that all protect the defenders? Have they spent a night in a frozen foxhole on outpost duty? Have they had a Kamikaze plane come ripping into the bridge or a warship killing the entire chain of command? Have they ever tried to bail out of an out of control bomber as it spirals inexorably to ground? Most will answer no.

And then, those against use of the bomb will bring out photographs of children with skin peeling from their backs and corpses incinerated by 10,000 degrees fahrenheit heat to show the pathos and carnage wrought by our peacemaker. For every picture they exhibit, I'll show one of a GI face down partially buried in the sand with steel helmet tilted forward as the surf gently laps over his boots. Or I'll show a photo of an airman beheaded by a Samurai swordsman, or an emaciated POW after 3 years of confinement.

No. It was the right thing to do. Dropping the bomb saved lives on both sides in the short and in the long run. If the revisionists want to march now against future atomic warfare, I will walk with them side by side and carry any standard or banner required. This is now, and that was then.

**Milton F. Miller, MD**



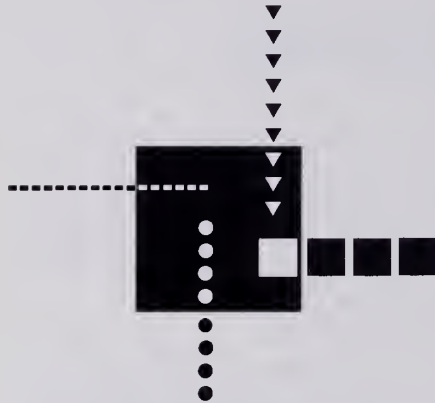
# Organized Medical Staff Section

**Twenty Sixth Assembly Meeting**

**November 30–December 4, 1995**

**Washington Hilton and Towers Hotel**

**Washington, DC**



**Representation,  
Education and  
Networking**

Send an AMA member physician representative from your hospital or health care delivery system to the 1995 Interim American Medical Association Organized Medical Staff Section (AMA-OMSS) Assembly Meeting to be held November 30 - December 4, 1995 in Washington, DC. Don't pass up this opportunity to participate in AMA's policy-making process and make a difference in the way your representative organization responds to managed care and other important issues facing today's physician. You can also gain valuable knowledge and make useful contacts by attending OMSS educational programs and networking functions.

With the growth of managed care, the merging of hospitals, and the corporatization of medicine, the traditional roles and responsibilities of the medical staff are being challenged. To help physicians respond effectively, OMSS's educational program titled, "Creating the Future and Getting There First," will focus on changing the medical staff paradigm, thinking in the future tense, and strengthening the physicians' leadership role in the governance of hospitals, integrated delivery systems, and managed care organizations. More specifically, the session will address:

- The changing environment and the value of self-governance;
- How to reengineer and improve medical staff functions and processes;
- The attributes of a successful self-governing physician organization (PO);
- The components of governance and resources needed to develop a community-based PO;
- What criteria should be utilized in making partnering decisions; and
- How to manage risk, respond to legal and logistical challenges, and raise capital.

For new insight into how to increase physician involvement in your community attend the AMA-OMSS Interim Assembly Education Program on Friday, December 1 from 2:30 pm to 5:30 pm in Washington, DC.

"The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians."

"The AMA designates this medical education activity for up to 3 credit hours in Category 1 of the Physician's Recognition Award."

For more information please call **800 AMA-3211** and ask for the AMA's Department of Organized Medical Staff Services.

**American Medical Association**

Physicians dedicated to the health of America





*Marla Vieillard*

## Where Are We Going? What Do We Want?

abuse, breast cancer awareness, and becoming aware and part of the legislative issues that affect medicine. They have developed programs and materials for all Alliance members to use. They have shown why we must be active to support the Medical profession, and why we must be active and vocal to our legislators to protect not only our patients, but also the profession that our spouses have chosen to be a part of. Socialized medicine and total managed care will not be the panacea our patients and families have been led to believe by the government and legislative media blitz.

With these volatile, important issues facing us, why is membership falling in certain areas? Why are medical professional families not joining the groups that support their professions and help protect their rights to practice medicine? Why are they not monetarily supporting the legislators who are favorable to medicine, by at least the equivalent to one month's Provider Tax?

How do we stop the apathy and the decline in membership? Where are people's priorities? What does it take to drive individuals to act upon their concerns and to get involved? I believe many know they should, but it has become too easy to say, "Been There, Done That," or "I'm not up on politics." Well, time doesn't stand still and neither will the government's driving need to control medicine. Everyone of us **MUST** be active.

There is one Alliance member to each six members of the KMA. I would not think of not being a member. I believe we can't fix a situation if we do not know what makes it work, what the organization's principles are, or

what the bylaws address. And we must put some of our own ideas and efforts into these organizations.

I accept the fact that it is not easy for everyone to speak up and be involved. They feel shy or unimportant. Everyone is important. I know everyone is important whether I agree or believe in each of their attitudes or ideals. I will consider and give some time thinking over their point of view.

Dr Clark, President of the Kentucky Medical Association, gave strong encouragement to all members of the House of Delegates at the Annual September Convention for their spouses to become Alliance members. If there is not an active county Alliance in their area, our Board, KMAA, will be willing to help them organize one. The Member-At-Large membership is available until their county is organized. Every Member Is Important. We need all of us working together to make and keep medicine as a profession that cares about patients and their families.

Now, with Dr Clark's encouragement, how do you see the future of the Alliance? How can we make it happen? What Do You Want that hasn't been offered?

I am your State President, and as your leader I am stressing to you that the problems facing medicine will not vaporize. We all must be active and I will gladly pass on to the Board your ideas. You must communicate, educate yourself on issues, and be involved. Contact me at 1-606/836-7082; e-mail MARWYLL@AOL.COM; mail 94 Poplar Street, Russell, KY 41169-1441; Fax-call for the new number.

**Marla Vieillard**  
KMAA President

**T**his is not the article that I had planned to write. But recent events and comments often alter one's plans.

What do we want? Ask a child what he or she wants for a birthday, Christmas, or any other special occasion, and they usually will reel off a list of potential wants or ideas. Ask a teenager and the list will usually be money, a car, and freedom. Ask an adult and they may wish for free time, someone to understand them, less stress, and financial freedom. Ask a senior citizen and they often will say I don't need a thing, or maybe to travel, or a friend to combat the loneliness. They have lost friends and maybe their spouse. Each age has different needs, as do organizations.

Well, now I am asking Alliance members and spouses. What do you want from the Alliance? What should we do that we have not tried or what should we keep on doing? Our Federated membership, (National, State, and County) is to help us grow and work on problems or issues together. The American Medical Association Alliance has been foresighted on issues of violence—media, family, spouse





## *Sometimes The Deadliest Intersections Aren't The Busiest.*

There are no flashing lights. There is no crossing gate. No, most highway-rail crossings in America are marked just like this one — with the familiar railroad crossing “crossbuck” sign. Everywhere it stands, the crossbuck delivers a simple, life-saving message. And what it says is this: “*at absolutely any time, there may be a train on this track.*” Now that may seem obvious, but apparently it’s not.

Last year alone, there were over 2,000 car-train crashes at crossings marked with only a crossbuck. And about half of those crashes left people dead or maimed for life. So please, when you see a crossbuck, treat it as a “yield” sign. Slow down, look, listen and stop if you see or hear a train. That will keep even the quietest intersection peaceful. And it will keep you and the people you are driving alive.



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17-18 — Perinatal/Neonatal Symposium, Radisson Plozo Hotel, Lexington, KY. **Contact:** Office of Continuing Medical Education, K112 Kentucky Clinic, University of Kentucky, Lexington, KY 40536-0284; phone 800/204-6333; FAX 606/323-2008.

1996

## FEBRUARY

4-7 — Southeastern Surgical Congress, Hyatt, Tompo, FL. **Contact:** Sec/Dir, R. P. Burns, MD, UT Coll of Med, 921 E 3rd St, Ste 400, Chattanooga, TN 37403; phone 404/607-8958.

5-7 — Cardiovascular Conference at Snowshoe (1621), Snowshoe, W VA. Sponsored

by the American College of Cardiology. **Contact:** American College of Cardiology, 9111 Old Georgetown Rd, Bethesda, MD 20814-1699; phone 800/257-4739; FAX 301/897-9745.

## APRIL

26-May 3 — 55th Annual American Occupational Health Conference, Son Antonio Convention Center, Son Antonio, TX. **Contact:** ACOEM, 55 W Seegers Rd, Arlington Heights, IL 60005; telephone, 708/228-6850; FAX 708/228-1856.

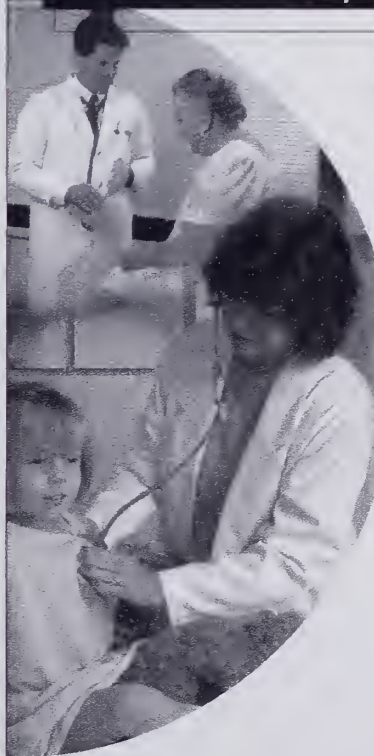
### Call for Papers!

"Uncertain Times: Preventing Illness, Promoting Wellness" is the theme for the 1996 International Conference on Physician Health to be held February 7-10, 1996, at the Sheraton San Marcos Hotel in Chandler, Arizona. Presentations dealing with any aspect of physician health, including issues of well-being, impairment, disability, treatment, and education are welcome. Of particular interest are: Stress and Physician health; Epidemiologic data; The effects of violence directed at physicians; Violence occurring within physicians' families; Patient exploitation; Mental illness, including substance abuse; Physical illness and disability; Special populations; Comparative data across states or countries; Physician well-being and family functioning.

For more information or to request an abstract submission form, call Elaine Tejcek, AMA, at 312/464-5066 or FAX your inquiry to 312/464-5841.

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## PHYSICIAN'S RECOGNITION AWARDS

**L**isted below are KMA member physicians in Kentucky who have earned the AMA's Physician Recognition Award (PRA) from August 1994 through July 1995.

The Award was established by the AMA House of Delegates of the American Medical Association in 1968 "to encourage physician participation in continuing medical education and to recognize physicians who have voluntarily completed programs of continuing medical education." In December 1992, the AMA House of Delegates revised the requirements for the PRA. Physicians now have two choices for PRA certification — the standard certificate and the PRA certificate "with Special Commendation for Self-Directed Learning." A minimum of 150 credit hours of CME must be earned over a consecutive 3-year period to qualify for the Standard PRA Certificate. Of these 150 hours, at least 60 must be in AMA/PRA Category 1. Ninety hours of education can be

### **Allen**

Mark S. Weis, MD

### **Barren**

James P. Crews, MD

### **Bell**

Puneet Goenka, MD  
Madhan Mohan, MD

### **Bourbon**

Matilal C. Patel, MD

### **Boyd**

J. Wesley Johnson, MD

### **Boyle**

David C. Liebschutz, MD  
Robert W. Stigall, MD

### **Breckinridge**

James G. Sills, MD

### **Bullitt**

Fe L. Bautista, MD

### **Caldwell**

Algimantas L. Jecius, MD

### **Campbell**

Paul S. Kappes, MD  
Todd M. Kirchoff, MD  
James M. Petit, MD

### **Christian**

Harry J. Dempsey, MD  
Hugh K. Dougherty, MD  
Joseph T. Fuqua, MD

Lyndon S. Goode, MD

Don L. Perkins, MD

Jonathan N. Terhune, MD

George R. Valentini, MD

Francis M. Van Meter, MD

### **Clay**

Javier A. Vasquez, MD

### **Crittenden**

Howard G. Maddux, MD

### **Daviess**

Garry N. Binegar, MD

Tristan S. Briones, MD

James R. Gould, MD

Suk K. Kim, MD

Tom S. Maddox, MD

### **Estill**

Charles E. Terry, MD

### **Fayette**

James L. Bauer, MD

Elizabeth J. Borrone, MD

Edwin L. Bunch, MD

Robert J. Bunge, MD

Robert J. Dempsey, MD

Stephen G. Edelstein, MD

Harold T. Faulconer, MD

Michael D. Hagen, MD

William D. Medina, MD

Sibu P. Saha, MD

Thomas K. Slabaugh, MD

Verner Stillner, MD

William D. Weitzel, MD

Henry G. Wells, MD

Sheila H. Woods, MD

### **Fleming**

William G. Bacon, MD

### **Floyd**

William B. Cook, MD

Mary A. Hall, MD

### **Franklin**

George F. Hromyak, MD

### **Graves**

George V. Jirak, MD

### **Grayson**

Romeo C. Baliton, MD

### **Greenup**

Gerald B. Reams, MD

### **Hardin**

Leslie T. Cottrell, MD

Joseph M. Dew, MD

Amos G. Hall, MD

Robert E. Robbins, MD

### **Henderson**

Randall S. Brown, MD

John W. McClellan, MD

Pramod V. Prabhu, MD

### **Hopkins**

Iyad A. Jabi, MD

Ronald A. Berry, MD

Charles R. Dodds, MD

Mitchell D. Kaye, MD

Jon R. Love, MD

Thomas S. Neely, MD

in Category 2 which includes CME lectures and seminars not designated Category 1; medical teaching; articles, publications, books, and exhibits; and nonsupervised CME such as self-instruction, consultation, patient care review, and self-assessment. Credit hours are based on hour-for-hour participation in a continuing medical education activity with the number of hours rounded to the nearest whole hour. For the new Special Commendation Certificate, the requirements differ from the Standard Certificate in that applicants cannot include reading of medical literature as qualifying for Category 2 and applicants had to obtain a minimum of 20 credit hours of Category 1 and 20 credit hours of Category 2 annually.

We congratulate these physicians who have distinguished themselves and their profession by their commitment to continuing education.

### **Jefferson**

Charles C. Barr, MD  
Frank O. Bonnarens, MD  
Lee R. Chutkow, MD  
Ronald N. Collier, MD  
Hal M. Corwin, MD  
John L. Cowan, MD  
Robin M. Floyd, MD  
Will S. Foster, MD  
Katherine M. Garrison, MD  
Robert R. Goodin, MD  
Lisa B. Graziano, MD  
Udayakumar Kayerker, MD  
Theresa M. Keeling, MD  
Barbara L. Kennedy, MD  
Steve F. Lipson, MD  
James F. Molloy, MD  
Philip E. Podruch, MD  
Bernard O. Rand, MD  
Joseph E. Sadtler, MD  
Frank G. Simon, MD  
Bennie C. Slucher, MD  
George C. Stege, MD  
James F. Swift, MD  
Frances E. Weinstock, MD  
Larry J. Wilson, MD  
Richard S. Wolf, MD  
Robert H. Zax, MD

### **Johnson**

Steve L. Roberts, MD

### **Kenton**

Jerry R. Crabbs, MD  
Christine Horner-Taylor, MD  
Richard E. Park, MD  
Henry A. Wells, MD  
Bahram Ziaie, MD

### **Laurel**

David W. Douglas, MD  
Paul R. Smith, MD

### **Lincoln**

Charles G. Click, MD

### **Logan**

Roy B. McEndre, MD

### **Lyon**

Algimantas L. Jecius, MD

### **Marion**

Salem M. George, MD  
Richard L. Litt, MD  
Brian F. Scott, MD

### **Marshall**

Wendell E. Gordon, MD

### **Martin**

Raymond D. Wells, MD

### **Mason**

Daniel D. Beineke, MD  
Phillip H. Yunker, MD

### **McCracken**

Edwin L. Grogan, MD  
Robert M. Haugh, MD  
Kurt Klauburg, MD  
Laxmaiah Manchikanti, MD

### **Nicholas**

Jose T. Lorenzo, MD

### **Perry**

George R. Chaney, MD  
Walter M. Shelly, MD

### **Pike**

Baretta R. Casey, MD  
William M. Johnson, MD  
Mary L. Lu, MD  
Elvis R. Thompson, MD  
Rodolfo G. Valera, MD

### **Pulaski**

Khalid Iqbal, MD  
Rodney J. Oakes, MD

### **Rowan**

Robert E. Sexton, MD

### **Russell**

James E. Monin, MD

### **Spencer**

William K. Skaggs, MD

### **Taylor**

Eugene E. Shively, MD

### **Trigg**

Thornton E. Bryan, MD

### **Warren**

Richard J. Wiesemann, MD

### **Wayne**

James K. Phillips, MD



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**PEOPLE**

**Donald H. Mosley, MD**, a retired cardiologist in Louisville, was among the 12 Louisville-area volunteers recently honored with 1995 Bell Awards for community service. Dr Mosley was a founding father of and served for 2 years as vice president of the board of directors of the Jefferson County Medical Society Morgan Center, a shelter for the homeless. For the past 3 years, he has been executive director of the Hospital Hospitality House, which provides patients' families with a comfortable, affordable place to stay while they are in the hospital. Dr Mosley oversees the daily operation of the house, acting as liaison to the downtown hospitals, recruiting volunteers, and giving support and counsel to families of the sick. He also serves as editor of its newsletter, and serves on medical-ethics committees in the city.

**Robert R. Goodin, MD**, KMA Immediate Past President, has been recognized by the University of Louisville School of Medicine and Alumni Association as the 1995 Irvin S. Abell, Sr Award recipient.

**Charles F. Allnutt, MD**, of Lakeside Park, KY, has been named as a fellow of the American College of Radiology (ACR). Dr Allnutt practices at St. Elizabeth Medical Center and St. Luke Hospital. Selected for his outstanding contributions to the field of radiology, Dr Allnutt was named as one of 130 new fellows by the College's Board of Chancellors.

**Claire Louise Caudill, MD**, a Morehead physician, and Lucille Caudill Little, her sister, were recently honored by the Kentucky Advocates for Higher Education for promoting and supporting higher education in Kentucky.

A special program was recently held at Pediatric Grand Rounds in the Norton Hospital Auditorium to commemorate a *Festschrift* to **Billy F. Andrews, MD**, *Journal of Perinatology* Vol 15, No 2, March/April, 1995. According to the report received by the JKMA, this was the first to be written for a professor at the University of Louisville and its Medical School. **Larry N. Cook, MD**, professor and Chairman of the Department of Pediatrics, presided over the ceremony and made comments about Dr Andrews' contributions. **David Adamkin, MD**, Professor of Pediatrics, Director of Neonatal Medicine and Director of Nurseries, Kosair Children's Hospital and Women's Pavilion, the Norton's Hospital, edited and contributed to the *Festschrift* along with 19 other former residents, neonatal fellows, faculty, associates, and friends. A Commemorative Plaque from the *Journal of Perinatology* acknowledging the honor was presented to Dr Andrews by Dr Adamkin.

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**UPDATES**
**U.S. News & World Report Ranks UK College of Medicine**

The University of Kentucky College of Medicine was listed among the top 10 primary care medical schools in the United States for the fifth consecutive year by *U.S. News & World Report*. Scoring 85.5 out of a possible 100, the College of Medicine was third (tied with Michigan State University) on a list of 62 medical schools with the highest proportion of graduates entering primary care. According to the report from UK, this was the highest ranking the College of

Medicine has yet achieved in the annual survey. The College was 11th out of 62 in the category of academic reputation.

**Vaccine May Prevent Common, Deadly Diarrhea Virus**

The University of Louisville reports that a group of viruses that cause diarrhea in 90% of the world's children may soon be preventable thanks to a vaccine tested at the University. The vaccine, developed by the National Institute of Allergy and Infectious Diseases, prevented severe rotavirus-caused diarrheal disease in more than 80% of the infants who received it, says pediatric professor **George C. Rodgers, MD**.

**Endoscopic Ultrasounds Could be Key to Finding Cancers**

According to a report from the University of Louisville, their doctors are using a procedure that dramatically improves the odds of successfully finding and treating some gastrointestinal cancers. The procedure, internal endoscopic ultrasound, is 30% more accurate than previous methods, says **Steven A. McClave, MD**. The endoscope enables doctors to see the tumor, while the ultrasound gives them a highly detailed map of its structure. The report states that the procedure is particularly effective in treating cancers of the stomach, colon, esophagus, and pancreas, and that in some cases it also allows doctors to treat the tumors endoscopically, eliminating the need for more extensive surgery.

**Heart Problems in Athletes**

Each year, several high school athletes die suddenly from previously unknown heart ailments. While the

odds against sudden death are literally a million to one, parents should be aware of the warning signs, says University of Louisville pediatric cardiologist **Frederick W.**

**Arensman, MD.** According to Dr Arensman, the deaths are almost always the result of arrhythmia. He says parents first should look at family history to see if others have died suddenly and should analyze if their son or daughter has fainted or seemed close to fainting. Also, Dr Arensman says that chest pains or shortness of breath could point to potential problems.

## Hopkins

**Vivian M. Hobayan, MD** — RHU

200 Clinic Dr, Madisonville 42431

1986, U of Santo Tomas, Philippines

**Lawrence M. Katz, MD** — P

200 Clinic Dr, Madisonville 42431

1983, U of Missouri, Kansas City

**W. Deon Perkins, DO** — AN

200 Clinic Dr, Madisonville 42431

1991, Kirksville Coll of Osteopathy

**Orlando Schaening, MD** — ID

200 Clinic Dr, Madisonville 42431

1990, U Central del Caribe, Puerto Rico

**Jonah O. Ukiwe, MD** — NEP

200 Clinic Dr, Madisonville 42431

1988, Spartan Health Sciences U, West Indies

## Hardin

**Edward J. Gross, MD** — PS

2005 Oriole Dr, Elizabethtown 42701

1989, U of Miami

## Leslie

**George C. Koppuzha, MD** — IM

PO Box 1893, Hyden 41749

1986, St Johns Med Coll, Bangalore,

India

## Madison

**James W. Stutts, DO** — FP

108 Whispering Hills Dr, Berea 40403

1986, Philadelphia College of

Osteopathic Med

## Mason

**Dirk R. Davis, MD** — GE

991 Medical Park Dr, Ste 203,

Maysville 41056

1986, U of Tennessee, Memphis

**Joseph F. Morris, MD** — FP

1350 Medical Park Dr, Maysville 41056

1988, Dalhousie U, Canada

## Warren

**Bryan G. Crum, MD** — OPH

3132 Smallhouse Rd, Bowling Green

42104

1989, Bowman Gray, Winston-Salem

**Impaired Physicians Program**  
9000 Wessex Place, Suite 305  
Louisville, KY 40222

**New Phone Number**

502/425-7761

**New Fax Number**

502/425-6871

## NEW MEMBERS

*Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.*

### Christian

**Nabil Malek, DO** — IM

500 Clinic Dr, Hopkinsville 42420

1992, Texas Coll of Osteopathic Med,

Ft. Worth

**G. Michael Sabbah, MD** — IM

500 Clinic Dr, Hopkinsville

1986, U of Rome

### Fayette

**Gates E. Hoover, MD** — A

1725 Harrodsburg Rd, Lexington

40504

1989, Louisiana State U, New Orleans

**Susan E. Liddle, MD** — HEM

3080 Harrodsburg Rd, #200, Lexington

40503

1988, Case Western Reserve, Cleveland

**David G. Haas, MD** — AN

1752 Brook Park Dr, Lexington 40504

1990, U of Kentucky

A  
GIFT  
that  
remembers...

by helping  
others to live

When you lose someone dear to you — or when a special person has a birthday, quits smoking, or has some other occasion to celebrate — memorial gifts or tribute gifts made for them to your Lung Association help prevent lung disease and improve the care of those suffering from it.

AMERICAN  LUNG ASSOCIATION®  
The Christmas Seal People®



# PHARMACEUTICALS AVAILABLE TO KENTUCKY PHYSICIANS CARE

These Pfizer/Roerig/Pratt & Searle pharmaceuticals may be prescribed and dispensed under the program:

## Pfizer Labs

Diabinese® Tablets (Chlorpropomide) Rx  
Diabinese® Tablets Unit-Dose Pak (Chlorpropomide) Rx  
Feldene® Capsules (Piraxicam) Rx  
Feldene® Capsules Unit-Dose Pak (Piraxicam) Rx  
Minipress® Capsules (Prozosin HCl) Rx  
Minipress® Capsules Unit-Dose Pak (Prozosin) Rx  
Minizide® 1 Capsules (1 mg. Prozosin and 0.5 mg. Polythiazide) Rx  
Minizide® 2 Capsules (2 mg. Prozosin and 0.5 mg. Polythiazide) Rx  
Minizide® 5 Capsules (5 mg. Prazasin and 0.5 mg. Polythiazide) Rx  
Maderil® Tablets (Rescinamine) Rx  
Narvasc® (2.5, 5 and 10 mg.) Rx  
Pracordia® Capsules (nifedipine)  
Pracordia® Capsules Unit-Dose Pak (nifedipine)  
Pracordia XL® Extended Release Tablets (nifedipine)  
Pracordia XL® Extended Release Tablets Unit-Dose Pak (nifedipine)  
Renese® Tablets (Polythiazide) Rx

Renese®-R Tablets (2 mg. Polythiazide and 0.25 mg. Reserpine) Rx  
Terramycin® Capsules (Oxytetracycline HCl) Rx  
Vonsil® Capsules (Oxamniquine) Rx  
Vibra-Tabs® (Doxycycline hyclate) Rx  
Vibra-Tabs® Unit-Dose Pak (Doxycycline hyclate) Rx  
Vibramycin® Calcium Syrup (Doxycycline calcium arol suspension) Rx  
Vibromycin® Hyclate Capsules (Doxycycline hyclate) Rx  
Vibromycin® Hyclate Capsules Unit-Dose Pak (Doxycycline hyclate) Rx  
Vibramycin® Monohydrate for Oral Suspension (Doxycycline monohydrate) Rx  
Vistoril® Capsules (Hydroxyzine pamoate) Rx  
Vistoril® Capsules Unit-Dose Pak (Hydroxyzine pamoate) Rx  
Vistoril® Oral Suspension (Hydroxyzine pamoate) Rx  
Zithromox® Capsules (Azithromycin)

## Roerig

Antivert® (Meclizine HCl) Rx  
Antivert® Tablets Unit-Dose Pak (Meclizine HCl) Rx  
Atorox® (Hydroxyzine HCl) Rx  
Atarax® Tablets Unit-Dose Pak (Hydroxyzine HCl) Rx  
Cefabid® (Cefaperozone sodium) Rx  
Diflucan® (Fluconazole) Oral and Parenteral Antifungal Rx  
Diflucan® Oral Suspension (Fluconazole)  
Diflucan® 150 mg Tablet (fluconazole)  
Geacillin® (Corbenicillin indanyl sodium) equivalent to 382 mg. carbenicillin Rx  
Glucatal® Tablets (glipizide)  
Glucatal® Tablets Unit-Dose Pak (glipizide)  
Glucatal® XL Extended Release Tablets (glipizide)  
Isaject® Permapen® (Penicillin G benzathine) Aqueous Suspension Rx  
Marox® (Hydroxyzine HCl [ATARAX®]-Theophylline-ephedrine sulfate) Rx  
Navane® Capsules (Thiathixene) Rx  
Navane® Capsules Unit-Dose Pak (Thiathixene) Rx  
Navane® Concentrate (Thiathixene HCl) Rx  
Navane® Intramuscular (Thiathixene HCl) Rx  
Narvasc® Tablets (amlodipine besylate)

Narvasc® Tablets Unit-Dose Pak (amlodipine besylate)  
Pfizerpen® for Injection (Penicillin G potassium) Buffered Rx  
Polymyxin B Sulfate Sterile Rx  
Sinequan® Capsules (Doxepin HCl) Rx  
Sinequan® Capsules Unit-Dose Pak (Doxepin HCl) Rx  
Sinequan® Oral Concentrate (Doxepin HCl) Rx  
Spectrobid® Oral Suspension (Bacampicillin HCl) Rx  
Spectrobid® Tablets (Bacampicillin HCl) Rx  
Toa® Capsules (Troleandomycin) Rx  
Terra-Cortril® Ophthalmic Suspension (Oxytetracycline HCl and hydrocortisone acetate) Rx  
Terramycin® Intramuscular Solution (Oxytetracycline) Rx  
Terramycin® Ophthalmic Ointment with Polymyxin B Sulfate (Oxytetracycline HCl with polymyxin B sulfate) Rx  
Unosyn® (Ampicillin sodium/sulbactam sodium) Rx  
Urabiatic® 250 (250 mg. Oxytetracycline HCl 250 mg. sulfamethizole 50 mg. phenazopyridine HCl) Rx  
Vibromycin® Intravenous (Doxycycline hyclate for injection) Rx  
Vistaril® Intramuscular Solution (Hydroxyzine HCl) Rx  
Zalaf® Tablets (Sertraline) Rx

## Pratt Division

Glucatal® Tablets (Glipizide) Rx  
Glucatal® Tablets Unit-Dose Pak (Glipizide) Rx  
Feldene® Capsules (Piraxicam) Rx  
Feldene® Capsules Unit-Dose Pak (Piraxicam) Rx  
Pracordia® Capsules (Nifedipine) Rx

Pracordia® Capsules Unit Dose Pak (Nifedipine) Rx  
Pracordia XL® (Nifedipine) Extended Release Tablets Rx  
Pracordia XL® (Nifedipine) Extended Release Tablets Unit-Dose Pak Rx  
Zalaf® Tablets (Sertraline) Rx

## Searle

Aldactazide® tablets (spironolactone with hydrochlorothiazide)  
Aldactone® tablets (spironolactone)  
Calon® SR caplets (verapamil HCl)  
Calon® caplets (verapamil HCl)  
Cytatec® tablets (misoprostol)

Kerlane® tablets (betaxolol HCl)  
Nitradisc® discs (nitroglycerin)  
Norpace® capsules (disopyramide phosphate)  
Norpace® CR capsules (disopyramide phosphate)

# PHARMACEUTICALS AVAILABLE TO KENTUCKY PHYSICIANS CARE

These Johnson & Johnson pharmaceuticals may be prescribed and dispensed under the program:

## Iolab Corporation

Argyrol® S.S. (mild silver protein)  
Atropisol® Ophthalmic Solution (atropine sulfote)  
Cotorose® (chymotrypsin)  
Dexocidin® Ophthalmic Suspension and Ointment (dexomethosone, neomycin and polymyxin B. sulfates)  
Dexomethosone Sodium Phosphate Ophthalmic Solution 0.1%  
Dexomethosone Sodium Phosphate 4 mg/ml (for injection)  
Epinephrine  
E-PILO® Ophthalmic Solution (epinephrine bitartrate-pilocarpine HCl)  
Eserine Sulfate Sterile Ophthalmic Solution  
Fluorescein Sodium  
Fluor-Op® Ophthalmic Suspension (fluorometholone .1%)  
Funduscein® -10, -25 Injection (fluorescein sodium)  
Gentocidin® Solution and Ointment (gentamicin sulfote)  
Gentomicin 40 mg/ml, 80 mg/2 ml (for injection)  
Glucose-40 Sterile Ophthalmic Ointment  
Homotropine Hydrobromide  
Inflomose® Forte Ophthalmic Solution (prednisolone sodium phosphate)

Inflomose® Mild Ophthalmic Solution (prednisolone sodium phosphate)  
Iocore® Balanced Salt Solution  
Miochol® Introocular & System Pak (acetylcholine chloride)  
Neomycin, Polymyxin B sulfates, and Hydrocortisone Ophthalmic Suspension  
Neomycin, Polymyxin B sulfates, and Gromidicin Ophthalmic Solution  
Neomycin Sulfate/Dexomethosone Sodium Phosphate Ophthalmic Solution  
Phenylephrine HCl 10%/2.5%  
Pilocor® Ophthalmic Solution (pilocarpine HCl)  
Sulf-10® Ophthalmic Solution (sodium sulfacetamide)  
Tetrocaine HCl  
Vosacidin® Ophthalmic Solution (sulfacetamide sodium-prednisolone sodium phosphate) & Ointment (sulfacetamide sodium-prednisolone acetate)  
Vosocon-A Ophthalmic Solution (naphazoline HCl-oxetazoline phosphate)  
Vosocon Regular Ophthalmic Solution (naphazoline HCl 0.1%)  
Vososulf® Ophthalmic Solution (sulfacetamide sodium-phenylephrine HCl)

## Janssen Pharmaceutica, Inc.

\*Durogesic® Transdermal system (fentanyl)  
Hismonal® Tablets (ostemizole)  
Imodium® Capsules (loperamide HCl)  
Nizoral® Cream (ketoconazole)  
Nizoral® Shampoo (ketoconazole)

Nizoral® Tablets (ketoconazole)  
Propulsid® Tablets (cisopride)  
Sporonox® Capsules (econazole nitrate)  
Vermox® Tablets (mebendazole)

## McNeil Consumer Products Company

Chemet® Capsules (succimer)

Pedioprofen™ Suspension (ibuprofen)

## McNeil Pharmaceutical

Floxin® Tablets (ofloxacin)  
Holdol® Tablets and Concentrate (haloperidol)  
Holdol® Deconote Injection (haloperidol)  
Motrin™ Suspension (ibuprofen)  
Poncreose® Capsules (pancrelipase)  
Poncreose® MT Capsules (pancrelipase)  
Poroflex® Copelets (chlorzoxazone)

Porofon Forte® DSC Copelets (chlorzoxazone)  
Tolactin® Capsules and Tablets (tolmetin sodium)  
Tylenol® with Codeine Tablets and Elixir (acetaminophen and codeine phosphate)  
\*Tylox® Capsules (oxycodone hydrochloride and acetaminophen capsules USP)  
Voscor® Tablets (bepidil HCl)

## Ortho Biotech

Procrit® Injection (epoetin Alfa)

## Ortho Pharmaceutical Corporation

Aci-Jel® Therapeutic Vaginal Jelly  
Floxin® Tablets (ofloxacin)  
Micronor® Tablets (norethindrone)  
Modicon® Tablets (norethindrone/ethinyl estradiol)  
Monistat® 3 Suppositories (miconazole nitrate)  
Ortho-Cept® Tablets (desogestrel/ethinyl estradiol)  
Ortho-Cyclen® Tablets (norgestimate)  
Ortho Diaphragm Kit  
Ortho® Dienestrol Cream (dienestrol)  
Ortho-Est® Tablets (estropipate)  
Ortho-Novum® Tablets (norethindrone/mestronol) or (norethindrone/ethinyl estradiol)

Ortho Tri-Cyclen® Tablets (norgestimate)  
Protostat® Tablets (metronidazole)  
Sultrin® Triple Sulfo Cream and Vaginal Tablets (sulfothiazole/sulfacetamide/sulfobenzamide)  
Terozol® Cream and Vaginal Suppositories (terconazole)  
Erycette® Topical Solution (erythromycin)  
Grifulin V® Tablets/suspension (griseofulvin microsize)  
Meclon® Cream (meclocycline sulfosolycylate)  
Monistat Derm® Cream (miconazole nitrate)  
Perso-Gel® & Perso-Gel® W (benzoyl peroxide)  
Retin-A® Cream/Gel/Liquid (tretinoin)  
Spectazole® Cream (econazole nitrate)

\*Durogesic® and Tylox® (CII controlled substances) will be replaced with other products.



# PHARMACEUTICALS AVAILABLE TO KENTUCKY PHYSICIANS CARE

These Abbott Laboratories and Novo Nordisk pharmaceuticals may be prescribed and dispensed under the program:

## Abbott Laboratories

Biaxin<sup>™</sup> for Oral Suspension (clarithromycin)  
 Biaxin<sup>™</sup> Tablets (clarithromycin)  
 Cortrol<sup>®</sup> Filmtab<sup>®</sup> Tablets (cortisol HCl)  
 Cylert<sup>®</sup> Tablets C<sup>IV</sup> (pemoline)  
 Depokate<sup>®</sup> Sprinkle Capsules (divalproex sodium)  
 Depokate<sup>®</sup> Tablets (divalproex sodium delayed-release tablets)  
 E.E.S. 400<sup>®</sup> Filmtab<sup>®</sup> (erythromycin ethylsuccinate tablets, USP)  
 E.E.S. Granules (erythromycin ethylsuccinate for oral suspension, USP)  
 E.E.S. 200 Liquid (erythromycin ethylsuccinate oral suspension, USP)  
 E.E.S. 400 Liquid (erythromycin ethylsuccinate oral suspension, USP)  
 Eryderm<sup>®</sup> (erythromycin topical solution, USP 2%)  
 Eryped<sup>®</sup> Chewable Tablets (erythromycin ethylsuccinate tablets, USP)  
 Eryped<sup>®</sup> Drops (erythromycin ethylsuccinate for oral suspension, USP)  
 Eryped<sup>®</sup> 200 (erythromycin ethylsuccinate for oral suspension, USP)  
 Eryped<sup>®</sup> 400 (erythromycin ethylsuccinate for oral suspension, USP)  
 Ery-Tab (erythromycin delayed-release tablets, USP, enteric-coated)  
 Erythracin<sup>®</sup> Stearate Filmtab<sup>®</sup> (erythromycin stearate tablets, USP)  
 Erythramycin Base Filmtab<sup>®</sup> (erythromycin tablets, USP)  
 Fera-Folic-500<sup>®</sup> Filmtab (controlled-release iron with vitamin C and folic acid)  
 Fera-Gradumet<sup>®</sup> Filmtab (controlled-release dose of iron)  
 Hytrin<sup>®</sup> Tablets (terazosin hydrochloride tablets)  
 Iberet<sup>®</sup> Filmtab<sup>®</sup> (controlled-release iron, vitamin C and B-complex vitamins)  
 Iberet-500 Filmtab<sup>®</sup> (controlled-release iron with vitamin B-complex and vitamin C)  
 Iberet-Folic-500<sup>®</sup> Filmtab<sup>®</sup> (controlled-release iron with vitamin C and B-complex vitamins including folic acid)  
 Iberet-Liquid Oral Suspension (iron, B-complex vitamins and vitamin C)

Iberet-500 Liquid Oral Solution (iron, B-complex vitamins and vitamin C)  
 K-Lor<sup>™</sup> 20 mEq. Powder Packets (potassium chloride for oral suspension, USP)  
 K-Lor<sup>™</sup> 15 mEq. Powder Packets (potassium chloride for oral suspension, USP)  
 K-Tob<sup>®</sup> 10 mEq. (750 mg.) (potassium chloride extended-release tablets, USP)  
 PCE<sup>®</sup> 333 mg. Tablets (erythromycin particles in tablets)  
 PCE<sup>®</sup> 500 mg. Tablets (erythromycin particles in tablets)  
 Prasam<sup>™</sup> Tablets C<sup>IV</sup> (estazolam tablets)  
 Surbex<sup>®</sup> Filmtab<sup>®</sup> (vitamin B-complex)  
 Surbex<sup>®</sup> with C Filmtab<sup>®</sup> (vitamin B-complex with vitamin C)  
 Surbex-T<sup>®</sup> Filmtab<sup>®</sup> (high-potency vitamin B-complex with vitamin C)  
 Surbex<sup>®</sup> 750 with Iron Filmtab<sup>®</sup> (high-potency B-complex with iron, vitamin E and 750 mg. of vitamin C)  
 Surbex<sup>®</sup> 750 with Zinc Filmtab<sup>®</sup> (zinc, vitamin B-complex and vitamins C and E)  
 VI-Doylin<sup>®</sup>/F Multivitamin Chewable Tablets  
 VI-Doylin<sup>®</sup>/F Multivitamin + Iron Chewable Tablets  
 VI-Daylin<sup>®</sup> Multivitamin Chewable Tablets  
 VI-Daylin<sup>®</sup> Multivitamin + Iron Chewable Tablets  
 VI-Doylin<sup>®</sup> Multivitamin Drops  
 VI-Doylin<sup>®</sup> ADC Vitamins Drops  
 VI-Doylin<sup>®</sup>/F Multivitamin Drops  
 VI-Doylin<sup>®</sup>/F ADC Vitamins Drops  
 VI-Doylin<sup>®</sup> Multivitamin plus Iron Drops  
 VI-Doylin<sup>®</sup> ADC Vitamins plus Iron Drops  
 VI-Doylin<sup>®</sup>/F Multivitamin plus Iron Drops  
 VI-Doylin<sup>®</sup>/F ADC Vitamins plus Iron Drops  
 VI-Doylin<sup>®</sup> Multivitamin Liquid  
 VI-Doylin<sup>®</sup> Multivitamin plus Iron Liquid

## Novo Nordisk

### HUMAN INSULIN (recombinant DNA origin)

Novolin<sup>®</sup> R  
 Novolin<sup>®</sup> L  
 Novolin<sup>®</sup> N  
 Novolin<sup>®</sup> 70/30  
 Novolin<sup>®</sup> R PenFill<sup>®</sup>  
 Novolin<sup>®</sup> N PenFill<sup>®</sup>  
 Novolin<sup>®</sup> 70/30 PenFill<sup>®</sup>

### HUMAN INSULIN (semi-synthetic)

Velosulin<sup>®</sup> Humon  
 Insulatard<sup>®</sup> Human  
 Mixtard<sup>®</sup> Human 70/30

### PURIFIED INSULIN

Regular-R  
 Lente<sup>®</sup> L  
 NPH-N  
 Velosulin<sup>®</sup> R  
 Insulatard<sup>®</sup> N  
 Mixtard<sup>®</sup> 70/30

### STANDARD INSULIN

Regular-R  
 Lente<sup>®</sup> L  
 NPH-N  
 Semilente<sup>®</sup> S  
 Ultralente<sup>®</sup> U

# PARTICIPATING PHARMACIES

## KPC PHARMACY PROVIDER PROGRAM

**Adair**  
DBA Columbia Pharmacy  
Madison Square Drugs & Chymist

**Allen**  
Carpenter Dent Drugs  
Stovall Prescription Shop  
Williams Pharmacy

**Anderson**  
The Medicine Shoppe  
Reliable Drugs

**Ballard**  
Wickliffe Pharmacy, Inc

**Barren**  
Ely Drugs, Inc  
Glasgow Prescription Center  
K-Mart Pharmacy  
Towne & Country Drugs

**Bell**  
City & County Drug  
Farris Drugs  
Jeff's Pharmacy  
K-Mart Pharmacy  
Krager Company  
Pineville Hos. Out-Pt Pharmacy  
Rxco Friendly Pharmacy  
SuperX Drugs  
Total R Care Pharmacy

**Boone**  
Boone County Drugs  
Burlington Pharmacy  
K-Mart Pharmacy  
SuperX Drugs  
Turfway Pharmacy

**Bourbon**  
Glen's Drugs  
Harne's Ardrey Drug  
The Medicine Shoppe

**Boyd**  
K-Mart Pharmacy  
Laynes Pharmacy  
McMeans Pharmacy  
Reliable Drugs  
SuperX Drugs

**Boyle**  
Grider Pharmacy  
K-Mart Pharmacy  
Krager Pharmacy  
Leake Pharmacy  
SuperX Drugs  
Taylor Drug

**Bracken**  
Dean's Pharmacy

**Breathitt**  
Jackson Prescription Ctr  
Reliable Drugs  
Rite-Aid Pharmacy

**Breckinridge**  
Save-Rite Drugs  
Towne & Country Pharmacy

**Bullitt**  
Taylor Drugs

**Caldwell**  
Payless Discount Pharmacy  
The Pharmacy Corner Enterprise

**Calloway**  
Clinic Pharmacy  
Holland Drugs  
Reliable Drugs  
Safe-T Discount Pharmacy  
The Medicine Shoppe  
Walter's Pharmacy

**Campbell**  
Alexandria Drugs  
Martin's Pharmacy  
Newport Drug Center  
SuperX Drugs

**Carlisle**  
Arlington Pharmacy, Inc

**Carroll**  
Parklane Pharmacy  
Webster Drugs

**Carter**  
Horton Brother & Brown  
K-Mart Pharmacy  
Rose Pharmacy

**Christian**  
Express Pharmacy  
Horn Prescription Shop  
Jennie Stuart Medical Center  
Reliable Drugs  
Save Mare Drug  
The Medicine Shoppe  
Winn-Dixie Pharmacy #1630

**Clark**  
Corner Drug Store  
Day Drugs  
K-Mart Pharmacy  
Reliable Drugs  
SuperX Drugs  
Winn-Dixie Pharmacy

**Clay**  
Family Drug Center  
H & N Drug  
Medi Center Drugs

**Crittenden**  
Glenn's Apothecary

**Cumberland**  
Smith Pharmacy

**Daviess**  
Danahauer Drug Company  
Emery Centre Pharmacy  
Greene's Pharmacy  
Harreld's Drug Store  
Mayfair Pharmacy  
Medical Plaza Pharmacy  
Medicine Shoppe  
Nation's Medicines  
Reliable Drugs  
Taylor Drug #21  
Wal-Mart Pharmacy  
Whitesville Drug Store  
Winn-Dixie #1653

**Edmonson**  
Prescription Shop

**Fayette**  
Hi-Acres Pharmacy  
Hubbard & Curry Pharmacy  
Hutchinson Drug  
K-Mart Pharmacy  
All Kroger Pharmacies  
Lexington-Fayette Cty Health Dept  
Professional Arts Apothecary  
Randall's Pharmacy  
Taylor Drugs  
The Medicine Shoppe  
U of Ky Chandler Medical Center  
Warehouse Drugs  
Winn-Dixie Pharmacy  
Woodhill Pharmacy

**Fleming**  
Plaza Pharmacy

**Floyd**  
Archer Clinic Pharmacy  
Betsy Layne Pharmacy  
Brooks Pharmacy, Inc  
Mud Creek Clinic Pharmacy  
Our Lady Of The Way Hospital

**Franklin**  
East Side Pharmacy  
Fitzgerald Drugs  
K-Mart Pharmacy  
Kroger Pharmacy  
Medicine Shoppe  
Reliable Drugs  
Taylor Drugs  
The Prescription Center

**Fulton**  
City Super Drug  
Evans Drug Company  
Rumfelt Drug  
SuperX Drugs

**Garrard**  
Sutton Pharmacy

**Grant**  
Grant County Drugs

**Graves**  
K-Mart Pharmacy  
Stanes Drugs  
SuperX Drugs  
Wilson Rexall Drugs

**Grayson**  
Caneyville Drugs  
Clarksan Drug Store  
Reliable Drugs

**Green**  
Model Drug Store

**Greenup**  
Reliable Drugs  
Scott Drugs  
Stultz Pharmacy

**Hardin**  
Jeff's Prescription Shop  
K-Mart Pharmacy  
Krager Company

Lincoln Trail Pharmacy  
Radcliff Drugs  
Showers & Hays Drugs  
SuperX Drugs  
Taylor Drugs  
Winn-Dixie Pharmacy #1690  
Woolridge Drug

**Harlan**  
Cloverbrook Clinic Pharmacy  
Lynch Med. Services Pharmacy  
SuperX Drugs

**Harrison**  
Eastside Pharmacy Of Cynthiana  
Lee Drugs

**Hart**  
Branstetter Pharmacy  
Clarks  
Mallory Drugs

**Henderson**  
Dunaway's Imperial Pharmacy  
Family Pharmacy North  
Family Pharmacy South  
K-Mart Pharmacy  
Reliable Drugs  
T & T Drugs

**Henry**  
Cook's Pharmacy

**Hickman**  
Perkins Pharmacy

**Hopkins**  
Earlington Pharmacy  
Family Drugs  
Madisonville Pharmacy  
Nation's Medicines  
Professional Drugs #2  
Reliable Drugs  
SuperX Drugs

**Jackson**  
Annville Pharmacy  
Campbell's Drug  
Clinic Pharmacy  
Rite Aid #3270

**Jefferson**  
Alliant Health System Pharmacy  
Applied Pharmacy Therapeutics  
Art Jacob Prescription Shoppe  
Beechmant Pharmacy  
Band Pharmacy  
J.G. Brawn Cancer Center  
Colonial Drugs  
Cox's Pharmacy  
Cox's Pharmacy #1  
DBA Hametek Pharmacy  
Harding Pharmacy  
Holdaway Drugs  
Hume Pharmacy  
K-Mart Pharmacy  
Koby Drug Company  
All Kroger Pharmacies  
Oak Drug Company, #1  
Parrino Pharmacy  
Rouben's Pharmacy  
St. Denis All Care  
All SuperX Drugs  
All Taylor Drugs



# PARTICIPATING PHARMACIES KPC PHARMACY PROVIDER PROGRAM

U of L Hospital Ambulatory Care  
Pharmacy  
Union Prescription Center  
Wal-Mart Pharmacies  
Warehouse Drugs  
Winn-Dixie Pharmacies

**Jessamine**  
Drug Mart  
Medicine Shappe  
Taylor Drugs

**Jahson**  
Bi-Rite Pharmacy  
K-Mart Pharmacy  
Reliable Drugs

**Kentan**  
Beringer Save Discount Drug  
Blank's Pharmacy  
Baekley Drugs  
Cherakee Drug Shappe  
Crestville Drugs  
Farrell Pharmacy  
Fart Mitchell Drug Shappe  
Fart Mitchell Pharmacy  
K-Mart Pharmacy  
Ludlaw Drugs  
Medical Village Pharmacy  
Marwessel Drugs  
Nie's Independence Pharmacy  
Save Discount Drugs  
All SuperX Drugs

**Knatt**  
East KY Health Services Center

**Knox**  
Cascia Drugs  
Knox Professional Pharmacy  
Sav-Rite Pharmacy

**Laurel**  
Family Drugs  
Kelley's Medical Arts Pharmacy  
Laurel Heights Nursing Home  
Landon City Drug Co.  
Landon-Carbin Pharmacy  
SuperX Drugs

**Lee**  
Stufflebean Pharmacy  
Three Farks Apatheary

**Letcher**  
Parkway Pharmacy  
Shapwise Pharmacy

**Lewis**  
Osman Pharmacy, Inc

**Lincaln**  
Coleman's Drug Store  
Rishie Drugs

**Livingstan**  
Glenn's Prescription Center

**Lagan**  
Gawer Drug Store  
Riley-White Drugs  
Wal-Mart Pharmacy

**Madison**  
Berea Hospital Out-Patient  
K-Mart Pharmacy  
Kraeger Company  
SuperX Drugs

**Magaffin**  
Clinic Pharmacy

**Marian**  
Hagan-O'Daniel Pharmacy  
Pat's Pharmacy  
Reliable Drugs  
Southall Pharmacy

**Marshall**  
Bentan Discount Pharmacy  
Draffenville Pharmacy  
J & R Pharmacy  
Nelson ValuRite Pharmacy  
Pay-N-Save Discount Drugs

**Martin**  
Blacklog Apatheary

**Masan**  
K-Mart Pharmacy  
Medical Arts Pharmacy  
Reliable Drugs  
Tancray Martar & Pestle

**McCracken**  
Davis Drugs  
K-Mart Pharmacy  
Katterjohn Drug Store  
Kraeger  
SuperX Drugs  
The Medicine Shappe

**McCreary**  
Burgess Drug Store  
Daugherty Drugs

**Meade**  
Riverview Pharmacy

**Mercer**  
Kraeger Company  
SuperX Drugs  
The Medicine Shappe

**Metcalfe**  
Metcalfe Drugs  
Nunn Drugs

**Mantgamery**  
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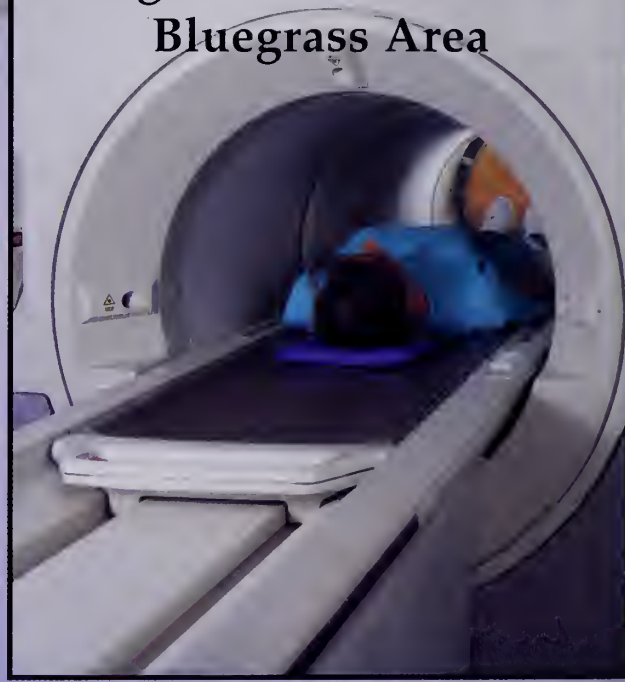
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*Season's  
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DECEMBER 1995  
VOLUME 93 NUMBER 12



JOSEPH SMITH, M.D.

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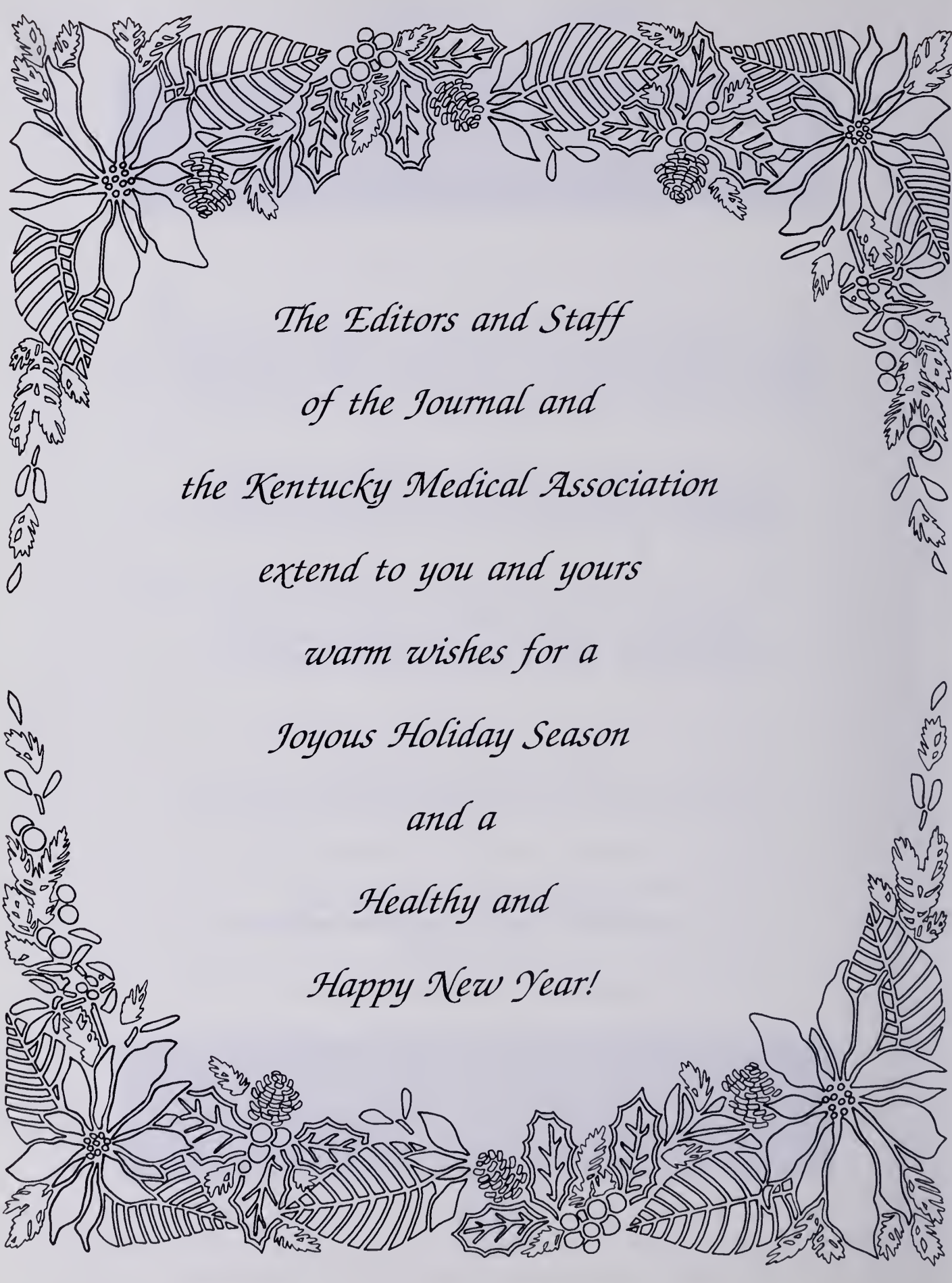
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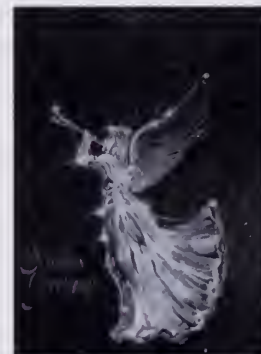
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extend to you and yours  
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JOURNAL OF THE  
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VOLUME 93, NUMBER 12

DECEMBER 1995

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**COVER:** This issue of the *Journal* provides extensive coverage of the 145th Annual Meeting, which was held September 18-21. An overview begins on page 560, with House of Delegates coverage beginning on page 575. Cover art by Lee Wade.

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Danny M. Clark, MD

## We Can Succeed

Comprehensive changes in House Bill 250 represent the hopes of many of our patients and our profession as we head for the 1996 session of the Kentucky General Assembly. Many groups, including state employees, the insurance industry, and others, are organizing and planning their legislative agenda. The Kentucky Medical Association was the first and foremost opponent of House Bill 250. It does nothing for the 400,000 Kentuckians who are without health insurance. The entire idea of health care reform was aimed at the 400,000 uninsured and reducing health care premiums. Unfortunately, KMA received very little help in 1994 and House Bill 250 passed with little objection from other organizations.

Now, 18 months later, the 400,000 uninsured remain, and insurance premiums for many have increased significantly. Physicians fought against overwhelming odds in 1994, against a governor who turned his back on those who had been his major supporters, and a legislative leadership that blindly followed the governor and several very liberal legislators. Kentucky adopted a plan in many ways like the Clinton plan. A plan that had been soundly rejected by the country, but, in Kentucky, we got much of it in House Bill 250.

Where does this leave us? Change — substantial change — in House Bill 250 is possible. It can be done, but you, your spouse, and your employees need to exercise your God-given constitutional right to lobby your legislators. You must seek them out, explain your position, and ask for their support. If they ignore you, you

---

*“Unless we have strong, local contact with each legislator, our efforts in Frankfort will be to no avail. It is impossible to lobby a legislator about an issue that does not seem to be of concern to his or her constituents.”*

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*“You, your spouse, and your employees need to exercise your God-given constitutional right to lobby your legislators.”*

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must be prepared to enter the political arena. We can no longer sit back complacently and allow politicians to do as they please.

Your Association and KEMPAC will provide you the tools, the opportunity, and the leadership to respond to those legislators who go out of their way to denigrate the profession and demagogue health issues while playing the class warfare game. We are in the process of establishing seminars to teach you, your spouse, your employees, and your friends how you can run for public office, how to manage a campaign, and how to work effectively within a political campaign. We will be taking these programs across the state. Please plan to participate in the various programs.

Finally, we have completed our 15 statewide pre-legislative seminars. Were you there? Many of you were



not. In several districts attendance was somewhere between sparse and lousy. We can repeal the tax, repeal the Discount Option Program, and reduce the power of the Health Policy Board, but it cannot be done by KMA officers and lobbyists alone. Unless we have strong, local contact with each legislator, our efforts in Frankfort will be to no avail. It is impossible to lobby a legislator about an issue that does not seem to be of concern to his or her constituents. Nothing is worse than a legislator who looks at you and says the doctors in my district must not be interested because none of them have called me. If doctors are not interested enough in their future to talk to their legislators and to their patients about their concerns, then we will not be successful, and you

will have earned House Bill 250 and its successors. In the next few months, you will be called upon to participate as you never have before, but if you will follow our lead, or we will follow your lead, the rewards to your patients and the profession can be significant.

As we enter the holiday season, Joyce and I wish you, your families, and your employees a very happy and safe holiday season. We hope that you enjoy them fully. It is a time for family and for friends, and a time to be thankful for the blessings that all of us enjoy. The next 4 months will be long and full of stress for all of us. With the help of everyone, we can succeed, but it will be a difficult task.

**Danny M. Clark, MD**  
President

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- ★ WHAT: KENTUCKY PHYSICIANS/SPOUSES 1996 LEGISLATIVE SEMINAR
- ★ WHERE: CAPITAL PLAZA HOLIDAY INN—FRANKFORT
- ★ WHEN: WEDNESDAY, JANUARY 17, 1996
- ★ 8:00—8:45 AM Continental Breakfast
- ★ 8:45AM—12:00 Program
- ★ 12:00—12:45 PM Lunch
- ★ 12:45—1:30 PM Program
- ★ 1:30 ADJOURN TO CAPITOL FOR VISITS WITH LEGISLATORS
- ★ WHY: PROVIDE OPPORTUNITY AND SUPPORT MATERIALS FOR PHYSICIANS AND SPOUSES TO MEET ONE-ON-ONE WITH THEIR LEGISLATORS TO DISCUSS ISSUES OF RELEVANCE TO PATIENTS AND THE PROFESSION
- ★ HOW: INVITED SPEAKERS INCLUDE THE LT. GOVERNOR; SPEAKER OF THE HOUSE; PRESIDENT OF THE SENATE; FOUR PHYSICIAN LEGISLATORS; CHAIRMAN OF THE HEALTH POLICY BOARD; AND COMMISSIONER OF WORKERS' COMPENSATION.
- ★ REGISTRATION: FREE (PRE-REGISTRATION REQUIRED)

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### 1996 LEGISLATIVE SEMINAR REGISTRATION FORM

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★ ADDRESS \_\_\_\_\_

★ \_\_\_\_\_

★ *Complete & Mail Form to: Kentucky Medical Association*

★ *Legislative Seminar Registration*

★ *301 N. Hurstbourne Pkwy #200*

★ *Louisville, KY 40222*



THE KENTUCKY MEDICAL ASSOCIATION  
and  
THE KENTUCKY MEDICAL ASSOCIATION ALLIANCE  
PRESENT  
1996 LEGISLATIVE SEMINAR  
January 17, 1996  
Capital Plaza Holiday Inn  
Frankfort, Kentucky

7:00 AM	CONTINENTAL BREAKFAST
7:50 AM	OPENING REMARKS <i>Harry W. Carlross, MD, Chair, Board of Trustees, Presiding</i>
8:00 AM	THE 1996 BUDGET — GRIMMS FAIRY TALES <i>John Cooper, Legislative Consultant</i>
8:10 AM	MEDICAID IN KENTUCKY — FACTS & FABLES <i>David Carby, KMA Director of Governmental Affairs</i>
8:20 AM	TORT REFORM — AN OXYMORON <i>William E. Doll, Legislative Counsel</i>
8:30 AM	LOBBYING — AFTER BOPTROT AND OTHER HORSE RACES <i>Don Chasteen, KMA Director of Public Affairs</i>
8:40 AM	MEDICINE AND POLITICS — A FAMILY AFFAIR <i>Jan Crase, KMAA Vice President of Legislation</i>
8:55 AM	HB 250 — THE GOOD, THE BAD, AND THE UGLY <i>Senator Nick Kafoglis, MD</i> <i>Representative Bob DeWeese, MD</i> <i>Senator James Crase, MD</i> <i>Representative Ernie Fletcher, MD</i>
9:55 AM	BREAK <i>William H. Mitchell, MD, KMA President-Elect Presiding</i>
10:10 AM	THE 1996 SESSION — A SENATE PERSPECTIVE FROM THE PRESIDENT <i>Senator John A. "Eck" Rose — President of the Senate</i>
10:30 AM	HEALTH SYSTEM REFORM — ONE SESSION REMOVED <i>Jack Hall — Chairman of the Health Policy Board</i>
10:50 AM	THE 1996 SESSION — A HOUSE PERSPECTIVE FROM THE SPEAKER <i>Representative Jody Richards — Speaker of the House</i>
11:10 AM	THE KMA 1996 LEGISLATIVE AGENDA — AND OTHER IMAGINARY DREAMS <i>Wally O. Montgomery, MD, Chair, KMA State Legislative Committee</i>
11:30 AM	WORKERS' COMPENSATION — DE JÁ VU ALL OVER AGAIN <i>Walt Turner — Commissioner, Workers' Compensation</i>
11:50 AM	POLITICAL ACTION — 28 CENTS A DAY — OR CHEAPER THAN A CUP OF COFFEE <i>William P. Vonderhaar, MD, Chair, KEMPAC Board of Directors</i>
12:00	LUNCH <i>Danny M. Clark, MD, KMA President Presiding</i>
12:45 PM	CABINET OF HUMAN RESOURCES DESIGNATE
1:15 PM	A CRITICAL TIME FOR THE PROFESSION — WHERE ARE YOU DOCTOR? <i>Danny M. Clark, MD, KMA President</i>
1:30 PM	ADJOURN TO THE CAPITOL

# In Memoriam

**T**ime has laid his hand  
Upon my heart, gently, not  
smiting it,  
But as a harper lays his open palm  
Upon his harp to deaden its vibrations.  
— LONGFELLOW

Oris Aaron  
Columbia

Lundy Adams  
Jeremiah

John L. Cassidy  
Covington

Ray A. Cave  
Leitchfield

Thomas G. Day, Jr  
Louisville

Marcus L. Dillon, Jr  
Lexington

Charles R. Gaba  
Louisville

J. Thomas Giannini  
Louisville

George F. Gilbert  
Lawrenceburg

Samuel S. Gordon  
Baltimore, MD

Thomas V. Gudex  
Columbia, TN

William L. Heizer  
Lexington

Jesse M. Hunt, Jr  
Wickliffe

Clifford V. Jennings  
Louisville

Raymond E. Jones  
Venice, FL

James M. Keightley, Jr  
Lexington

Wendell V. Lyon  
Ashland

Richard E. Mardis  
Campbellsville

John A. McKay  
Philpot

Lamar C. Meigs  
Ashland

Lawrence T. Minish  
Louisville

Carl B. Nagal  
Monticello

Jose M. Palacio  
Louisville

Frank R. Pitzer  
Hopkinsville

William O. Preston  
Lexington

Clarence E. Quaife  
Louisville

William J. Sandman, Jr  
Louisville

Frederick A. Scott  
Madisonville

John H. Scott, Jr  
Pikeville

C. B. Shacklette  
Vine Grove

Houston W. Shaw  
Louisville

Horace E. Titsworth  
Paducah

Hastel L. Townsend  
Louisville

Thomas J. Vaughan  
Berea

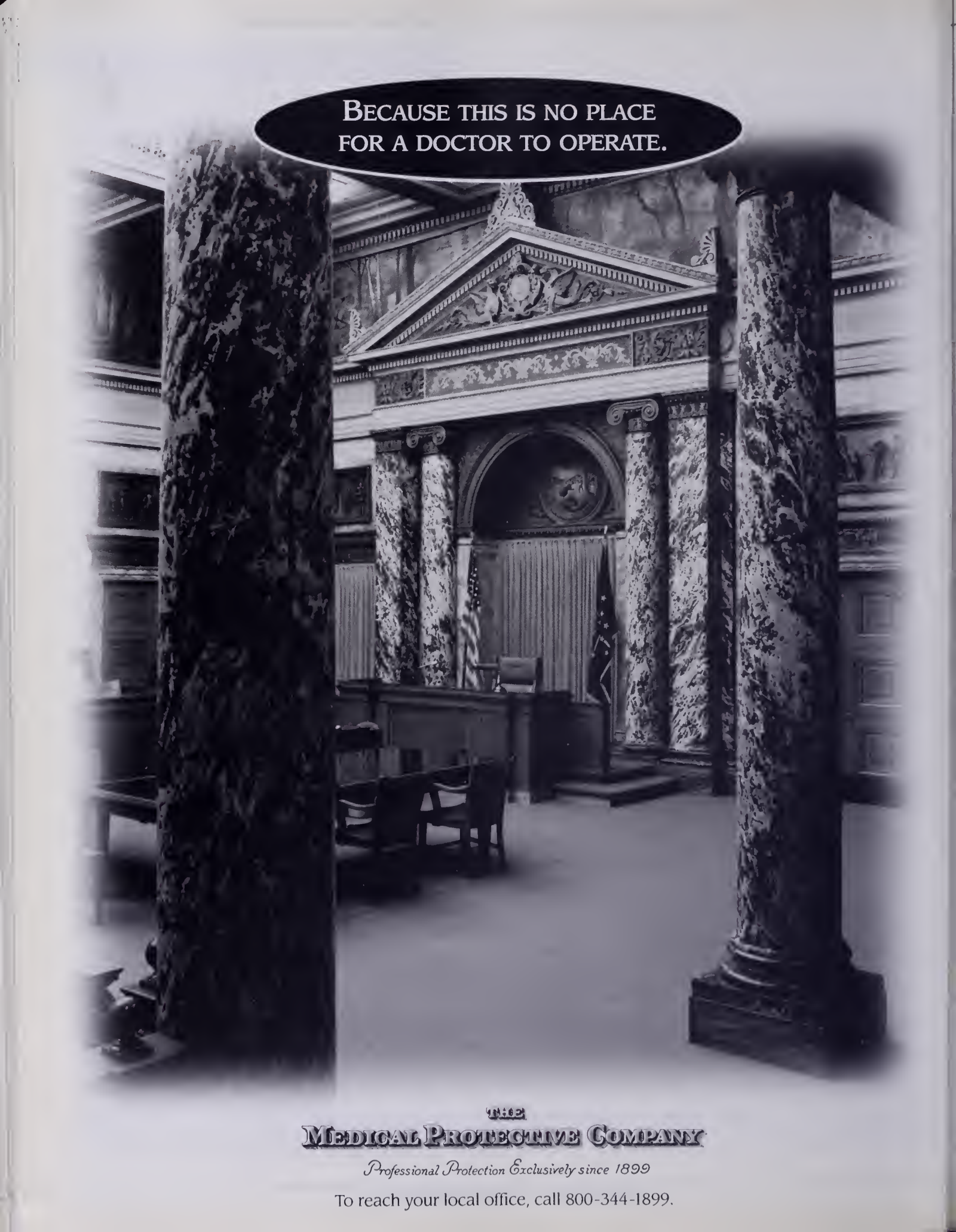
Carl A. Waldemayer  
Butler

Robert B. Warfield  
Lexington

John Watts  
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List of deceased physicians available to the *Journal* as of August 1, 1995.





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# Rupture of the External Iliac Artery During Pregnancy:

## A Case of Type IV Ehlers-Danlos Syndrome

Carol K. Brees, MD; Stanley A. Gall, MD

*Ehlers-Danlos Syndrome is a group of connective tissue disorders involving defects in collagen synthesis. Ten different types have been described. The most lethal of these is type IV, with up to 25% maternal mortality described. The defect in type III collagen can lead to rupture of arteries, bowel, or uterus.*

*We present a maternal mortality that occurred in a patient not previously known to have Ehlers-Danlos syndrome. She presented at 29 weeks gestational age with a ruptured external iliac artery. Further complications, including jejunal rupture and aortic disruption ultimately led to her demise. Postmortem examination ultimately confirmed the diagnosis of type IV Ehlers-Danlos syndrome.*

*Although type IV Ehlers-Danlos syndrome is rare, it carries a high risk for maternal morbidity and mortality. Therefore, it is important to be aware of the diagnosis prior to pregnancy and to have a high index of suspicion for arterial or viscus perforation in the face of acute abdominal findings.*

**E**hlers-Danlos syndrome refers to a group of connective tissue disorders, which are classically described as hyperextensibility of the joints and hyperdistensibility of the skin. Ten types of Ehlers-Danlos syndrome have been described, and it is now considered a heterogeneous group of disorders.<sup>1</sup> Type IV Ehlers-Danlos involves a defect in type III collagen. This type of collagen is particularly abundant in arterial walls, bowel wall, and uterus.<sup>1-4</sup>

Maternal mortality of up to 25% has been reported with type IV Ehlers-Danlos syndrome due to rupture of artery, bowel, and uterus.<sup>2</sup> We report a maternal death in a patient not previously known to have Ehlers-Danlos syndrome.

### Case Report

A 25-year-old white female, gravida 2, para 0-0-1-0 was admitted to the hospital at 29 weeks gestation with complaints of left lower quadrant and flank pain, accompanied by mild dysuria. The pain had begun suddenly on the day of admission.

Her prenatal course was remarkable for some spontaneous bruising noted at 12 weeks of gestation. She had been referred to a hematologist at that time and no coagulation abnormality was discovered, and the problem resolved.

Otherwise, past history was remarkable only for a first-trimester spontaneous abortion 1 year previously and a repair of "clubbed feet" in childhood.

Admission examination revealed a 5'6" 153# gravid female, in some discomfort, but no acute distress. Temperature was 100.0°F, pulse 144, blood pressure 129/77. Fetal heart tones were in the 150s and reactive. There were no uterine contractions. Examination was otherwise unremarkable except for marked left lower quadrant tenderness and flank pain.

Laboratory evaluation included a hemoglobin of 9.8 gm/dl, hematocrit of 29.6, platelets of 198,000, and a WBC of 25.1 with 75% segmented neutrophils and 12 band forms. Urinalysis showed greater than 500 rbc/hpf, 10-12 WBC/hpf, and 1+ bacteria on a catheterized specimen.

The patient was admitted with a diagnosis of pyelonephritis vs ureteric stone. Urine culture was sent. Kefzol IV was begun and a renal ultrasound was scheduled.

Four hours following admission, the patient got up to go to the bathroom and had a sudden increase of pain. She was noted to be pale and diaphoretic. Blood pressure was 60-80 systolic and she was tachycardic. Fetal heart monitoring

*From the Division of Maternal-Fetal Medicine, Department of Obstetrics and Gynecology, University of Louisville and Norton Hospital, Louisville, KY.*

*This article was prepared as a Maternal Mortality Report in cooperation with KMA's Maternal Mortality Committee, John W. Greene, Jr, MD, Chair.*



## Type IV Ehlers-Danlos Syndrome

showed a rate in the 40s. Neither blood pressure nor fetal heart rate responded to O<sub>2</sub>, repositioning, or fluids. The patient was taken for emergent caesarean delivery with the presumptive diagnosis of abruptio placenta.

At surgery a massive hemoperitoneum was discovered. Two liters of clot and free blood were in the abdomen, as well as a large retroperitoneal hematoma. Classical caesarean section was performed, with delivery of a 1620 gm female infant. Apgars were 0 at 1, 5, 10 and 15 minutes despite all resuscitative efforts.

The pelvis was packed and the uterus was closed. The source of bleeding could then be identified as a 1 cm tear in the external iliac artery. There was no obvious aneurysm. This tear was oversewn by the consulting vascular surgeon. The patient received multiple units of packed red blood cells and fresh frozen plasma throughout the procedure. A Jackson-Pratt drain was left in the retroperitoneal space, the abdomen was closed, and the patient was transferred to the intensive care unit. She had received 20 units of packed red blood cells, 20 units of fresh frozen plasma, and 20 units of platelets.

The patient did well on postoperative day 1. She was successfully extubated, her coagulopathy had corrected, and her hemoglobin and hematocrit were stable at 8.4 gm/dl and 26.7%.

Early on the morning of postoperative day 2 she had a sudden increase in blood from the Jackson-Pratt drain. Hemoglobin was 6.6 gm/dl and the patient was hypotensive, despite fluid boluses.

She was returned to the OR for emergent exploration. The previous arterial repair was intact, however there was bleeding from several mesenteric vessels and rupture of a segment of the jejunum. A 23.2 cm segment of jejunum was resected with reanastomosis. At this point the patient was not maintaining her blood pressure and aortic cross-clamping was performed to enable repair of bleeding sites. The aorta was disrupted by the cross-clamping and blood pressure could not be maintained, despite 23 units of packed red blood cells and 10 units of fresh frozen plasma. The patient expired.

Postmortem examination was notable for the absence of atherosclerotic changes. There was a 2 cm dissection of the ascending aorta as well as the transmural disruption below the celiac trunk, which was presumed secondary to cross-clamping. The external iliac artery repair was intact with a 5 cm area of medial dissection noted. The false

lumen showed hypertrophy and arterialization, suggesting that it may have been longstanding. The patient's musculature was noted to be soft and easily disrupted in all planes, and the small intestine serosa and muscularis separated easily. This was all felt to be suggestive of type IV Ehlers-Danlos syndrome.

Tissue was sent for cell culture. A defect in type I or type III collagen production initially was not identified. However, on repeat examination a subtle change in the mobility of the chains of type III procollagen was noted, which was highly suggestive of Ehlers-Danlos syndrome type IV. This was consistent with her clinical picture.

## Discussion

Ehlers-Danlos syndrome is not a single entity. The clinical picture of hyperelasticity of the skin, hyperflexibility, and easy bruising was defined by Ehlers and Danlos in the early 1900s.<sup>1,5,6</sup> Since that time, at least 10 types of Ehlers-Danlos syndromes have been described with different biochemical defects in the connective tissue.<sup>1</sup> Not all types have been characterized biochemically at this time.<sup>4</sup>

Type IV Ehlers-Danlos syndrome is the most lethal of this group of disorders. At least some of the mutations leading to defects in the synthesis structure or secretion of type III procollagen have been identified.<sup>4</sup> The defective type III collagen is then incorporated into the walls of arteries, bowel, and uterus, leading to weaknesses in these structures. Most authors have reported an autosomal dominant inheritance pattern,<sup>1,2,4,6</sup> although isolated cases have been reported,<sup>2</sup> as well as autosomal recessive patterns.<sup>1</sup> The diagnosis can be made by measurement of type III collagen production by dermal fibroblasts in cell culture with radioactive proline.

Pregnancy appears to be an especially vulnerable time for patients with type IV Ehlers-Danlos syndrome. Spontaneous rupture of the uterus, colon, pulmonary artery, aorta, renal artery, and vena cava have all been reported.<sup>1,2,5,6</sup> The maternal mortality has been reported to be as high as 25%.<sup>2</sup> This has led some authors to recommend that patients with Ehlers-Danlos type IV be counseled for early pregnancy termination.<sup>1,2</sup> At the very least these patients need to be informed of their risks and observed very closely for spontaneous rupture of an artery or viscous. One patient with Ehlers-Danlos type IV was successfully managed with hospitalization from 29

weeks until elective caesarean delivery at 36 weeks.<sup>3</sup>

Other types of Ehlers-Danlos syndrome appear to have minor bone and joint complications in pregnancy, but lethal events have not been reported.<sup>7,8</sup>

Our patient was not known to have type IV Ehlers-Danlos syndrome prior to her suffering two catastrophic events. However, rupture of the external iliac artery is rare, especially in the absence of atherosclerosis, trauma, or septicemia.<sup>9,10</sup> To be followed so soon by a spontaneous jejunal rupture suggests a tissue defect. In fact, surgeons consulting on the case remarked on multiple occasions that the tissues "didn't feel right." However, the only hints of connective tissue problems in her history were the "clubbed foot" repair in her childhood<sup>6</sup> and the bruisability that led to her negative hematologic work up. Had a connective tissue disorder been suspected, cell culture still did not prove type IV Ehlers-Danlos syndrome in initial testing.

This case underscores the difficulty of diagnosis of connective tissue disease, particularly type IV Ehlers-Danlos syndrome. Although it is rare, the potential lethality of this disease makes it important for obstetricians to be aware of this entity and to be vigilant for complications in those who have the diagnosis.

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## Information for Authors

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**Preparation** — Manuscripts should be typewritten in double spacing throughout, including references, tables, legends, quotations, and acknowledgments. Submit the original and one copy, retaining a copy for proofreading. Ordinarily articles should not exceed 3,000 words in length. Titles should include the words most suitable for indexing the article, should stress the main point, and should be short. A synopsis-abstract must accompany each manuscript. The synopsis should be a factual (not descriptive) summary of the work and should state the problem considered, methods, results and conclusions.

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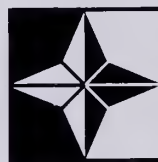


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# Responsible Reporting

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**“Between the information superhighway and the search for the story, writers seem to be making deals with the researchers to forward information before anyone else has it.”**

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**“T**oday’s newspaper had an article about . . .” “*Time* discussed . . .” It seems that everyday my patients come to the office, armed with the latest article about medicine. To have a knowledgeable patient makes the visit stimulating and the interaction mutually beneficial. To have the patient loaded with an article dealing with new medicines, procedures, or genetic breakthrough, about which we know little or nothing can be embarrassing. Between the information superhighway and the search for the story, writers seem to be making deals with the researchers to forward information before anyone else has it. Recently an article seemed to indict the calcium channel blocking agents, having quoted someone who claimed these medicines increased the incidence of myocardial infarction. Within hours the phones rang with patients ready to toss their medicine, and holding their chests until some remedy could be forwarded. Then others published information that at the least diminished the importance of this finding, and even refuted its conclusions. The cost in patient anxiety, physician time, and pharmaceutical business was enormous.

*New England Journal of Medicine*’s deal prohibits authors from discussing their work with the media before the editors do. These sanctions seem to give exclusive privilege, and subsequently the attendant notoriety to the journal, rather than the

researcher. The preamble, an article in the *New England Journal of Medicine* says . . . , subtracts from the author’s right to state his or her own case, and to explain the meaning of the work. Other journals expand this license to include using the articles and their authors to advertise their place in medical literature and the importance of reading and buying their journal. What started with the appropriate insistence of the journal to have exclusive publication rights to the content and writings in an article seems to be evolving into more of a proprietary right.

These are difficult times for the medical profession. One of the joys of practice is to communicate with our patients, often one on one and intimately. Their questions about symptoms or prognosis, ours about history or feelings, somehow cement the doctor-patient relationship. This recent external information injection seems often to upstage the physician, sometimes even preclude our notifying patients.

What role should the media play — a responsible one. Remember that the consumer may also be the patient. Let us read and think about the journal information. With some time and the opportunity for peer review, revision, and perhaps even some retraction, this research and discovery can be disseminated appropriately. Let the reader beware seems dangerous, if not immoral.

Stephen Z. Smith, MD



# Uncertain Times: Preventing Illness, Promoting Wellness

**1996 International  
Conference on  
Physician Health**

*Sponsored by the American Medical Association, the Canadian Medical Association, the Federation of State Medical Boards, the Federation of Medical Licensing Authorities of Canada, the Federation of State Physician Health Programs*

**February 7-10, 1996**

*In cooperation with the American Society of Addiction Medicine and the Society for Professional Well-Being*

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## **A New Focus...**

In these times of uncertain economic forces and rapidly advancing scientific knowledge, the stresses of keeping one's practice current and financially viable exact their toll on physicians. Physician health now includes a broad, pro-active, preventive approach of reducing all types of physician health problems and offering assistance before there is actual impairment.

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Presentations dealing with all aspects of physician health, including issues of well-being, impairment, disability, treatment, prevention and education are to be considered during the Conference. Topics of particular interest include: coping with changing economic practice circumstances; personal and professional stress and physician health; epidemiologic data; sexual boundary violations and other interpersonal problems; violence and physicians; women, elderly, minority, gay/lesbian, and other identified populations, among other issues.

## **Key Note Speakers will include:**

Frances Conley, MD - "Ruminations of an Academic Maverick"  
Leah Dickstein, MD - "Preparing Our Trainees for Healthy Living"  
Ronald Shellow, MD - "Diagnosis vs. Disability: Legal and Clinical Issues"

## **Pre-Conference Institutes will include:**

**Update on Chemical Dependency:** Edward Senay, MD, - *Cocaine*; Robert Swift, MD, PhD - *Current Pharmacologic Management Strategies*; Norman Miller, MD, - *Assessment and Management of Dual Diagnosis*

**Update on Psychiatry:** Morton Silverman, MD, - *Suicide*; Dominic Ciraulo, MD - *Newer Antidepressant Drugs and Drug Strategies*; Eberhardt Uhlenhuth, MD - *Anxiety Disorders: Changes in Diagnoses and Management*

**Women's Health, 1996:** Erica Frank, MD, MPH - *Research Needs and Plans*; Carol Scott, MD, MPH - *Violence as a Healthcare Issue*; Michael F. Myers, MD - *Relationships and Other Mental Health Issues*

## **Recreation**

When not discussing physician health issues, promote your own personal health. You will find an 18-hole championship golf course, several swimming pools, and tennis courts - two lit for night play. Enjoy jogging around the golf course, bicycling in the balmy southwestern breeze, horseback riding on the edge of town or working out at the nearby fitness center.

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Vicky & Jack Borders — Ashland  
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Clockwise from top left: Following his inauguration as the 145th President of the Kentucky Medical Association, Danny M. Clark, MD, Somerset, posed with his wife Joyce; DSA Award honoree, Nelson B. Rue, MD, Bowling Green, and his wife Sue were congratulated by KMA Immediate Past President and Awards Chair, Ardis D. Hoven, MD; President Clark is pictured with, L to R, President-Elect William H. Mitchell, MD, Vice President Donald R. Stephens, MD, and Secretary-Treasurer William P. Vonderhaar, MD.

Facing page, clockwise: Daniel H. Johnson, Jr, MD, President-Elect of the American Medical Association was the featured speaker at the first House of Delegates meeting; Dr Clark addressed the House of Delegates; President-Elect William H. Mitchell, MD, and his wife Winifred were escorted to the podium by two of his UK College of Medicine classmates (class of 1970), Past Presidents Ardis D. Hoven, MD, and Preston P. Nunnelley, MD Dr Hoven is pictured, but Dr Nunnelley was out of camera range.

# 145TH KMA ANNUAL MEETING







## Inauguration

**D**anny M. Clark, MD, a Somerset obstetrician-gynecologist, was inaugurated 1995-96 President of KMA at the 145th Annual Meeting held in Lexington, September 18-21. A graduate of the University of Cincinnati School of Medicine, Dr Clark served as a KMA Alternate Trustee from 1974 until 1980 and as Trustee from 1980 until 1986. He was elected Vice Speaker of the KMA House of Delegates in 1986 and served in that capacity until 1990 when he was elected Speaker, a position he held until 1994 when he was named President-Elect. He is a member of the Scientific Program, Legislative Quick Action, PLL, and Maternal and Neonatal Health Committees, and also serves on the Joint Oversight Group on Health Care Reform. Dr Clark has been a member of the Kentucky Board of Medical Licensure since 1986.

## Board of Trustees — Elections

The KMA Board of Trustees held its reorganizational meeting for the 1995-96 Association year on September 21, 1995. Acting as temporary Chair, KMA Secretary-Treasurer William P. Vonderhaar, MD, introduced the newly elected members of the Board and the new officers. William H. Mitchell, MD, Richmond, was elected President-Elect; and Don R. Stephens, MD, Cynthiana, was elected Vice President. C. Kenneth Peters, MD, Jeffersonton, was reelected Speaker, House of Delegates; and John W. McClellan, MD, Henderson, was reelected Vice Speaker.

The Board elected the Executive Committee members to serve with the President, President-Elect, Vice President, and Secretary-Treasurer for the 1995-96 KMA year. Harry W. Carlross, MD, Paducah, was elected Chair, Board of Trustees, and Scott B. Scutchfield, MD, Danville, was elected Vice Chair. Donald R. Neel, MD, Owensboro, and Russell L. Travis, MD,

Lexington, were named as Trustees-at-large.

It was noted that the KMA Executive Committee members also serve as the Board of Directors of KMA Physicians Services, Inc (KMA's holding company). The Board also made changes to the Kentucky Foundation for Medical Care Board of Directors in accordance with KFMC's Bylaws, and appointed KMA committees for the following year.

The next meeting of the Board was scheduled for December 13-14, 1995.

Five physicians were elected by the House of Delegates to serve on the 1996 Nominating Committee. Members elected were:

Thomas R. Slabaugh, MD  
Lexington, Chair  
Susan G. Bornstein, MD  
Louisville  
John T. Burch, MD  
Bowling Green  
Charles G. Nichols, MD  
Pikeville  
Charles T. Watson, MD  
Ashland

## President's Luncheon

The President's Luncheon guests honored outgoing President Robert R. Goodin, MD, and witnessed the installation of Danny M. Clark, MD, as the 145th President of KMA.

In his Inaugural Address, Dr Clark focused on the dramatic effect managed care has had on health care, and the growing outrage with House Bill 250. Notable comments included "Managed care strikes at the very heart of traditional medicine and the patient's right to choose. The defeat of the Clinton bill may be attributed to the question of whether patients have the right to choose their own physician. That issue is the single overriding principle which patients and physicians alike in this country can rally around. . . . House Bill 250 is a formidable challenge. We intend to fully exercise our options during the

1996 Session. We plan to educate our members and our patients regarding the excesses of HB 250. If the General Assembly fails to take us seriously then we will take the issue to the people during the 1996 elections . . . . We must keep our own house in order — the patient and the public must always come first. Only then can the private practice of medicine survive and flourish." Dr Clark's address is printed in its entirety in the October 1995 *Journal*.

## DSA Award

Each year the Kentucky Medical Association presents the Association's highest award to a member who has served their community, their state, and their profession with honor.

The 1995 recipient of the Association's most prestigious honor, the Distinguished Service Award, was bestowed upon Nelson B. Rue, MD, a Bowling Green surgeon. He was honored at the President's Luncheon not only for his contributions to the profession but also to his community.

Dr Rue served the Warren County Medical Society in practically every position and then concentrated his efforts on the state level by serving KMA. He served 6 years as Trustee, 3 of those as Chairman of the Board, as Vice President, and as KMA's 138th President. Health care for the poor has been a high priority for Dr Rue who was a driving force in the formation and development of the Kentucky Physicians Care program. One of the original appointees by the KMA Board to the committee which recommended the adoption of the KPC program, Dr Rue went on to serve for many years on the Health Care Access Foundation, including Vice President. Dr Rue is Immediate Past Awards Chairman, having served in this capacity for several years.

In her presentation of the award to Dr Rue, Ardis D. Hoven, MD, Chairman of the Awards Committee, included these comments:



*Top L to R: Board Chair Donald R. Stephens, MD, administered the presidential oath to Dr Clark; KMA Executive VP Robert R. Cox is pictured with newly elected President Clark. Center: President Robert R. Goodin, MD, presented the Educational Achievement Award to Frank B. Miller, MD (R), a Louisville surgeon. Bottom L to R: KMA Executive VP Cox, right, congratulated his longtime friend and colleague, William S. Conn, Jr, on being named recipient of a special KMA Layperson Award; Mason C. Rudd was accompanied by his daughter as he proudly displayed his KMA Award; Immediate Past President Hoven presented the 1994 DSA Award to Peter P. Bosomworth, MD, who retired in 1994 as Chancellor of the University of Kentucky.*







*Top to bottom: AMA President-Elect Johnson, left, discussed medical issues with C. Milton Young, MD, a Louisville internist; John D. Stewart, II, MD, a Lexington surgeon, was pictured during a break in House action; Ralph C. Morris, MD, a Louisville internist, chatted with AMA and KMA Past President, Hoyt D. Gardner, MD.*



"The 1995 DSA recipient has been extremely active on the local level, including membership in Rotary, Chamber of Commerce, and elder in his church. He has remained extremely involved in his profession and chosen specialty including past president and charter board member of the Kentucky Society for Gastrointestinal Endoscopy and past president, Kentucky Chapter American College of Surgeons. In addition, he has served as chairman and member of numerous KMA committees. He is a member of the Warren County Medical Society, KMA, AMA, Southern Medical Association, and the Southeastern Surgical Association.

Even though today's nominee has achieved much in life and is recognized throughout this state as one of Kentucky's most prominent physicians, his real pride and joy is his family. He has been married to the lovely Martha Sue Rogers for almost 45 years and they have five children and numerous, numerous grandchildren.

The 1995 DSA recipient exemplifies traits that promote the ideas and traditions of medicine and he is truly a worthy recipient of his profession's highest award."

## 1994 DSA Award

The 1994 recipient of the Distinguished Service Award was unable to attend last year's presentation and the award was formally presented at this year's Annual Meeting. The honor was bestowed upon Peter P. Bosomworth, MD, who retired in 1994 as Chancellor of the University of Kentucky.

Awards Chairman Hoven's comments highlighted the many contributions Dr Bosomworth has made to the medical community, including:

"The gentleman we honor today is a giant in the arena of medical education and in the pursuit of excellence. From 1962 to 1970, he accepted a wide range and scope of responsibilities at the University of Kentucky College of Medicine, the University Hospital, the Medical Center, and the organized medical profession of Kentucky. He arrived at the Medical Center as a young Chairman of a fledgling Department of Anesthesiology in April 1962. In seven short years, he built a Department of uncommon strength and versatility, which gained a national reputation as one of the outstanding anesthesia departments in the US.

During a disturbing and crucial period for the University Hospital, our award recipient assumed the trying position of Acting Hospital Director, and also, in actuality became a director of professional and educational services for the hospital staff. He also served as Associate Dean for Clinical Affairs in the Dean's office of the College of Medicine.

Recognizing his accomplishments, hard work, and success, the University continued to press our nominee into further services. In 1970, the University of Kentucky Board of Trustees promoted our 1994 Award recipient to the office of Vice President for the Medical Center at the University of Kentucky.

In 1994 he retired as Chancellor of the University of Kentucky. The tremendous growth and national reputation accorded to the University Medical Center and the UK Medical School is in a large part a product of our nominee's vision and drive to provide quality medical care to the Commonwealth.

While pursuing his vision of quality medical education, today's recipient recognized the need for intense involvement in his County Medical Society and State Association. He has served on numerous committees on the local and state level and is a highly esteemed Past President of the Fayette County Medical Society. He has been a participant in the KMA Annual Meeting for many years and served KMA with great distinction as Chair of the Scientific Program Committee for several years.

Our 1994 recipient of the DSA is the author of numerous scientific articles and is a recipient of the KMA Educational Achievement Award. When presenting that coveted award, the KMA President at the time noted,

"In all his varied and highly responsible capacities, he has performed with high competence, good judgment and rare concern for others. His humility belies the outstanding leadership he has brought."

#### Lay Person Award

The KMA Award, which is awarded to a lay person who has made significant contributions to the medical community, was presented to Mason C. Rudd, owner and founder of Rudd Equipment Company in Louisville.

Awards Chair Hoven noted that Mr Rudd's contributions to health care are exemplary with a lifelong record of voluntary public service which has benefited his city, his state, and his country.

"In the late 1960s, today's honoree became heavily involved and interested in the delivery of — and access to — health care in Jefferson County. He personally interceded in the political and public arena to ensure that indigent care was provided and that training of



Emery A. Wilson, MD, Dean of the UK College of Medicine, top photo, and Alfred L. Thompson, MD, Vice Dean for Clinical Affairs of UofL, center, thanked the Alliance and Association members for AMA-ERF contributions to their individual schools. Left: KMAA Past President Joyce Clark addressed the House of Delegates.







**L to R: "Kentucky's Country Doctor of the Year," Claire Louise Caudill, MD, is pictured with her nurse, Susie Halbleib, and KMAA President Marla Vieillard in front of a special display presented by the Alliance at their fall meeting.**

physicians continued. In 1971, he was named Chairman of the Jefferson County Board of Health and retains that title today. He struggled mightily to keep the old Louisville General Hospital afloat and personally intervened to ensure that General's mission remained on target. When time dictated the demise of Old General, our honoree became a major player in the planning of and construction of University Hospital. Today's recipient has remarkable people skills. According to one friend, our honoree 'in a ploy of brinksmanship, would walk in and get commitments for our money. He always had the ability to say the toughest things with a twinkle in his eye.'

Our honoree and his wife, Mary, have been generous benefactors to medicine and medical research. Their surgical teaching endowment with a \$500,000 gift has already grown to over \$1 million. The bequest is earmarked for new research programs, teaching awards, and funds grant proposals coordinated by the University of Louisville Department of Surgery.

Hiram C. Polk, Jr, MD, Chairman of the University of Louisville Department of Medicine noted, 'I have been through a dozen tight corners with him in 20 years and every time he has proven to be a man of his word, a man of total integrity, especially with respect to quality medical care for underprivileged individuals and the absolute demand for cooperation among hospital, physicians, medical schools, and other elements of the health care equation. There is no lay person in the United States more deserving of recognition.'

While our 1995 distinguished honoree placed primary emphasis on local problems, he has also been a major player on the state scene. He is a former chair of the Kentucky Certificate of Need and Licensure Board; Kentucky Council on Higher Education; member of the Kentucky Racing Commission, and recipient of numerous awards and honors.

His advocacy for medical education, public health outreach, environmental protection, and commitment to his community's high standards is legend. This vision and

foresight was perhaps best demonstrated when in 1987 while AIDS was still as one friend said, 'a dirty word,' today's honoree recognized that the disease was with us to stay and that we'd better learn to cope with it. The Jefferson County Health Department, under his leadership, became a national model for AIDS awareness, prevention, and provider of care for the AIDS patient.

In these brief moments we have only touched the surface in terms of our 1995 honoree's contributions to his fellow citizens. By his service, by his commitment to human kind — he has exemplified those traits which serve to define the purpose of this award."

### **Special Layperson Award**

The KMA Awards Committee elected to present an additional and special layperson award for 1995. This award was presented to William S. Conn, Jr, President and CEO of the Kentucky Hospital Association (KHA), who has announced his impending retirement. Under Mr Conn's leadership, the KHA has seen remarkable growth and is recognized as one of the most dynamic and respected associations in the Commonwealth.

Awards Chair Hoven commented: "A veteran of the US Navy, our nominee served 7 years with State Government in the Department of Mental Health and was Deputy Commissioner for Administration.

In 1971, our honoree joined the staff of Kentucky Hospital Association and 5 years later was elevated to President and CEO of KHA. During these years, the KHA has seen remarkable growth and is recognized as one of the most dynamic and respected associations in the Commonwealth.

Over the years, KMA has had a remarkable relationship with the Kentucky Hospital Association. KMA officers and staff have worked very closely with KHA during our



honoree's stewardship on numerous matters of mutual concern. Our CEO, Bob Cox, and today's nominee have worked in tandem on numerous association and legislative matters over the years, and the general cooperation between these two leading health related associations has been a key to many of our successes.

We were particularly impressed with the KMA/KHA forged alliance during the tumultuous health system reform debate. While we didn't overcome all the obstacles, the joint group was able to ward off many of the more onerous provisions supported by Brereton Jones.

Our honoree is the recipient of numerous awards and has been extremely involved in his community and state."

### Educational Achievement Award

The recipient of the 1995 KMA Educational Achievement Award was Frank B. Miller, MD, a Louisville surgeon. Dr Miller achieved distinction for his influence on medical education at the University of Louisville School of Medicine and throughout the state.

Dr Miller serves as Associate Professor of Surgery and as the Director, Trauma Service at the University of Louisville School of Medicine. He served as Director, Surgery Education in the Department of Surgery at U of L from 1985 to 1994. During that time he had a major influence on medical education at U of L in particular, and in the state as a whole through his efforts in the areas of scholarship, quality of patient care, statewide educational programs, as well as classroom and bedside teaching.

Dr Miller won the Golden Apple Award at the University of Louisville on six occasions between 1984 and 1992, as well as the Thomas Calhoon Teaching Award in 1986. In 1990, he received the University of Louisville



*Robert R. Goodin, MD, gave his exaugural address to the KMA House of Delegates, following a very successful year as the 144th President.*

Distinguished Teaching Award in the professional category. In addition, he was selected by the graduating senior residents in 1988 for the resident teaching excellence award.

Board certified in general surgery, Dr Miller also holds a Certificate of Added Qualifications in Surgical Critical Care from the American Board of Surgery. Other professional involvement includes service as Chair of the Kentucky Committee on Trauma; Chief, Region IV Committee on Trauma, and as a Senior Site Reviewer for the American College of Surgeons; fellowship in the ACS; membership in the Association for Academic Surgery, Association for Surgical Education, KMA, and the Jefferson County Medical Society, to name a few.

In community service, Dr Miller has actively supported the Clothe-A-Child Program and won their community service award in 1992 and 1993.

### Scientific Exhibit Award

Several excellent Scientific Exhibits

were displayed at the 145th KMA Annual Meeting. The award winner was an outstanding exhibit by Paul A. Sloan, MD, entitled "Undertreatment of Cancer Pain in America."

### Alliance AMA-ERF

During the first meeting of the House of Delegates, Joyce Clark, KMAA Past President, presented AMA-ERF checks to the two medical schools on behalf of the Alliance. Since 1950, the AMA-ERF has continually been supportive of quality medical education, with contributions now exceeding \$2 million annually. The extraordinary fund raising efforts of the AMA Alliance and the generosity of contributing medical families and private enterprise continue to secure AMA-ERF as a viable support for medical education.

In Kentucky, AMA-ERF funds are given proportionally to the two medical schools as designated by the donors. Alfred L. Thompson, MD, Associate Vice President for Health Affairs and Vice Dean for Clinical Affairs at the University of Louisville





*Left to right: Lisle Dalton, MD, a Lexington ob-gyn, and KMA 12th District Trustee and newly named Vice Board Chair, Scott B. Scutchfield, MD, Danville, chatted during a House break. Somerset colleagues Richard H. Weddle, MD, Kentucky State Senator James D. Crase, MD, and Joseph G. Weigel, MD, were pictured at the KEMPAC Banquet.*

School of Medicine, accepted a check from Mrs Clark for \$23,948.06, and Emery A. Wilson, MD, Dean of the University of Kentucky College of Medicine, accepted a check for \$15,852.44.

### **Fifty-Year Members**

Those KMA member physicians who have been practicing medicine for 50 years or more were recognized during the President's Luncheon. Achieving that status this year are Drs William H. Armbruster, Joseph A. Ballard, George R. Bierly, Jr, Benjamin D. Boone, William F. Clarke, James K. Conlan, Eugene H. Conner, Rachel G. Croft, George F. Doyle, James R. Freedman, Sylvan A. Golder, Armond T. Gordon, Donald L. Graves, William Burton Haley, William F. Hawn, Oscar J. Hayes, P. Patrick Hess, James B. Holloway, Sylvester G. Hunter, John C. Keeley, David W. Kinnaird, Robert C. Lam, Robert S. Leake, Ullin W. Leavell, Leonard Leight, Robert L. McClendon, Clyde T. Moore, Jack T. Morford, Robert B. Nolan, F. Albert Olash, C. Pittman Orr, Glenn L. Pfister, Heimo Reckmann, Harry C. Shirkey, Robert C. Smith, Harvey R. St. Clair,

Kenneth L. Stinnette, William T. Swartz, Alfred T. Wagner, Richard J. Wever, and Hylan H. Woodson, Jr.

### **In Memoriam**

During the first House of Delegates meeting, Secretary-Treasurer William P. VonderHaar, MD, requested that the audience stand for a moment of silence in memory of those physician members who had died in the last year. A list of the deceased appears on page 551 of this *Journal*.

### **KMA-MSS and RPS**

The 1995 joint Annual Meeting of the KMA Medical Student Section and Resident Physician Section featured an outstanding symposium on "Managing to Care in a Managed Care Environment," on September 19. Speakers included: Richard D. Clover, MD, Chair, University of Louisville Department of Family Medicine; Beverly M. Gaines, MD, Member, Kentucky Health Policy Board; James E. Hartert, MD, Chief Medical Officer, Humana Health Care Plans of KY, and William P. VonderHaar, MD, KMA Secretary-Treasurer and Chair, KMA Judicial Council.

The question-and-answer session following the panel inspired a lively debate on the future of medical care in this changing environment and was well received by the student/resident attendees.

As Chair of the AMA-RPS Governing Council, Judy Linger, MD, UK psychiatry resident, gave a report on legislative activities taking place at the national level.

### **KEMPAC**

The 33rd KEMPAC Seminar Banquet was held during this year's Annual Meeting on Monday, September 18, at the Hyatt Regency Hotel, Lexington. A large audience of physicians, spouses, Kentucky State Representatives, Senators, and their staff heard feature presentations by Gubernatorial Candidates Mr Larry Forgy and Lt Governor Paul Patton. KEMPAC Chair, William P. VonderHaar, MD, Somerset, presided at the meeting.

### **House Action Summary**

The Association's policymaking body, the House of Delegates, met on September 18 and again on



September 20 to consider issues including Health System Reform, Medicaid, and other medical issues.

Daniel H. Johnson, Jr, MD, President-Elect of the American Medical Association was the featured speaker at the September 18 House of Delegates meeting. Highlights of House actions at the September 20 meeting are listed below. Please refer to the House of Delegates section in this *Journal* for a complete text of the Committee Reports and Resolutions.

- Authorized the KMA Board of Trustees to act on behalf of KMA in connection with any and all proposals for the restructuring or reorganization of KMIC.

- Recommended KMA endorse legislation, regulations, and agency and institutional policies that authorize that health care services provided by Physician Assistants be reimbursed to the physician who supervises the Physician Assistant.

- Encouraged KMA to develop guidelines to increase participation for the development of Scientific Exhibits.

- Accepted the report of the Cancer Committee which recommended that KMA, in conjunction with appropriate specialty

*Top left: KEMPAC Board Chair William P. VonderHaar, MD, addressed the House of Delegates. Top to bottom: pictured at the KEMPAC Banquet were Democratic gubernatorial candidate Paul Patton and his wife Judi; Democratic candidate for Lt Governor, KMA member Steve L. Henry, MD; Republican gubernatorial candidate Larry Forgy and his wife Fran; and Kentucky State Legislative Chair Wally O. Montgomery, MD.*





groups, support HCFA's effort on a statewide basis to ensure that all eligible women receive mammography at a certified unit.

- Accepted the report of the Hospital Medical Staff Section which encouraged increased participation by physicians as well as support by organized medical staffs to the Hospital Medical Staff Section.

- Recommended KMA encourage the medical schools to include training in socioeconomic issues in the curricula of residents and students.

- Recommended KMA continue to show support for the Kentucky Organic Growers and the Commodity Growers Cooperative Association.

- Recommended KMA oppose legislation allowing optometrists to provide, act, or serve as primary care providers in performance of the practice of medicine, surgery, or laser surgery in the Commonwealth of Kentucky.

- Recommended KMA continue to monitor and take action to assure that information collected by the Health Policy Board protects the confidentiality of the physician-patient relationship, and that KMA oppose via reasonable legislative, administrative, and legal means, all onerous portions of House Bill 250, including those portions pertaining to reporting of data to the Health Policy Board by physicians.

- Accepted the report of the Committee on State Legislative Activities which recommended that the Kentucky General Assembly appoint a task force to study the issue of limited supply of extended care beds in Kentucky, and recommended that the use of laser equipment in surgery to be defined as the practice of medicine in any legislative bill introduced in the Kentucky General Assembly.

- Recommended KMA reaffirm its opposition to the provider tax and maintain, as a top legislative priority, the repeal of the provider tax by the 1996 Kentucky General Assembly.

- Recommended KMA work with the Legislature to develop a more timely process to allow decisions to be made

regarding advanced directives and termination of inappropriate medical intervention in patients who are wards of the state on a case-by-case basis.

- Recommended KMA support efforts to pass more appropriate legislation during the 1996 Legislature that would increase fines for illegal tobacco sales to minors so that enforcement efforts would be justified, and that KMA further support the proposed FDA regulations, specifically by writing a letter of support during the public comment period.

- Recommended KMA reaffirm the patient-physician relationship and the ability of the physician to do what is in the best interest of the patient, and that in the absence of definitive empirical data, discharge following delivery should be determined by the clinical judgment of physicians rather than health insurance guidelines; support legislation that would prevent third-party payors from interfering, by refusing to pay for care, with physician's clinical judgment regarding patient care, including timing of discharge.

- Recommended KMA begin studying and evaluating options for the development of a statewide health information network with a cost structure for participating physicians, and that these options be made available to the House of Delegates no later than the 1996 Annual Meeting.

- Recommended KMA advocate enactment of state laws or administrative regulations which provide for a point-of-service feature that is required in all managed care plans which have a closed panel and are approved by the Health Policy Board, and that KMA work to make a point-of-service feature be required in all non-ERISA managed care plans which have closed panels.

- Accepted the reports of the Committee on Maternal and Neonatal Health and the Committee on Child and School Health, and recommended KMA affirm support for "Parenting and Family Life Skills Education" curriculum in public schools.

- Accepted the report of the

Committee on Physical Education and Medical Aspects of Sports and acknowledged that physical examinations for participation in school sponsored sports should be done under the supervision of a physician.

- Recommended that KMA monitor any revision of the current Medicaid program and offer assistance of the Association in any discussion of changes in the Kentucky Medicaid program.

- Recommended that the KMA Board of Trustees closely monitor the development and implementation of block grant funding and take all reasonable, appropriate, and necessary action to assure that such funds are used solely for the provision of appropriate medical sources to eligible Medicaid recipients.

- Recommended KMA reaffirm its support for the KenPAC program and closely monitor and, if appropriate, oppose by reasonable lawful means, any Medicaid managed care program proposed to supplant KenPAC unless improvement over KenPAC would result.

- Recommended KMA actively promote a reasonable reimbursement rate for Medicaid providers and support adequate and broad-based state general funding for the Medicaid program.

## Attendance

This year's KMA meeting attracted an outstanding crowd of 2,059. Physicians numbered 1,081 and medical students 156, resulting in a very successful 145th KMA Annual Meeting at the Hyatt Regency Hotel/Lexington Center in Lexington. The 1996 Annual Meeting will be held in Louisville. The Board of Trustees has again selected the very accommodating and spacious Hyatt Regency Hotel/Commonwealth Convention Center to house the meeting. Over 22 specialty groups and an estimated 2600 registrants are expected to attend.

Please mark your calendars to attend the 1996 KMA Annual Meeting to be held September 25-28.

# ROLL CALL

## 1995 House of Delegates

### KMA Annual Meeting

#### OFFICERS

		First Meeting	Second Meeting
Speaker .....	C. Kenneth Peters, MD	Present	Present
Vice Speaker .....	Jahn W. McClellan, Jr, MD	Present	Present
President .....	Robert R. Goodin, MD	Present	Present
President-Elect .....	Danny M. Clark, MD	Present	Present
Vice-President .....	William H. Mitchell, MD	Present	Present
Secretary-Treasurer .....	William P. Vonderhaar, MD	Present	Present
AMA Delegate .....	Donald C. Borton, MD	Present	Present
AMA Delegate .....	Robert R. Goodin, MD	Present	Present
AMA Delegate .....	Ardis D. Hoven, MD	Present	Present
AMA Delegate .....	Wolly O. Montgomery, MD	Present	Present
AMA Delegate .....	Donald J. Swikert, MD	Present	Present
AMA Alternate Delegate ..	J. Gregory Cooper, MD	Present	Present
AMA Alternate Delegate ..	Bob M. DeWeese, MD	Present	Present
AMA Alternate Delegate ..	G. Irene Minor, MD	Present	Present
AMA Alternate Delegate ..	William B. Monnig, MD	Present	Present
AMA Alternate Delegate ..	Preston P. Nunneley, MD	Present	Present

#### TRUSTEES

District			
First .....	Harry W. Corloss, MD	Present	Present
Second .....	Donald R. Neel, MD	Present	Present
Third .....	William H. Klompus, MD	Present	Present
Fourth .....	Salem M. George, MD	Present	Present
Fifth .....	Joseph E. Kutz, MD	Present	Present
Sixth .....	Timothy K. Hulsey, MD	Present	Present
Seventh .....	Ronald E. Woldridge, MD	Present	Present
Eighth .....	Mork F. Pelstring, MD	Present	Present
Ninth .....	Donald R. Stephens, MD	Present	Present
Tenth .....	Russell L. Travis, MD	Present	Present
Eleventh .....	G. Irene Minor, MD	Present	Present
Twelfth .....	Scott B. Scutchfield, MD	Present	Present
Thirteenth .....	Kenneth R. Hauswald, MD	Present	Present
Fourteenth .....	E. D. Roberts, MD	Present	Present
Fifteenth .....	Paul R. Smith, MD	Present	Present

#### ALTERNATE TRUSTEES

District			
First .....	Dan M. Miller, MD	Present	Present
Second .....	Joseph H. Horpole, Jr, MD	Present	Present
Third .....	Charles R. Dodds, MD	Present	Present
Fourth .....	Jeffrey B. Richardson, MD	Present	Present
Fifth .....	Lorry J. Wilson, MD	Present	Present
Sixth .....	J. Michael Pulliom, MD	Present	Present
Seventh .....	John M. Patterson, MD	Present	Present
Eighth .....	John D. Amman, MD	Present	Present
Ninth .....	Robert L. McKenney, MD	Present	Present
Tenth .....	Andrew R. Pulito, MD	Present	Present
Eleventh .....	Richard A. Stone, MD	Present	Present
Twelfth .....	Donald E. Brawn, MD	Present	Present
Thirteenth .....	Susan H. Prasher, MD	Present	Present
Fourteenth .....	Vacant	Present	Present
Fifteenth .....	Roger A. Acosta, MD	Present	Present

#### PAST PRESIDENTS

Post President .....	Ardis D. Hoven, MD	Present	Present
Post President .....	William B. Monnig, MD	Present	Present
Post President .....	S. Randolph Scheen, MD	Present	Present
Post President .....	Prestan P. Nunneley, MD	Present	Present
Post President .....	Nelson B. Rue, MD	Present	Present

#### DELEGATES FIRST DISTRICT

		First Meeting	Second Meeting
BALLARD .....	Mortho C. Robinson, MD, Borlow	Present	Present
CALLOWAY .....	Robert C. Hughes, MD, Murroy	Present	Present
	Rob T. Williams, MD, Murroy	Present	Present
CARLISLE .....			
FULTON .....	Edward B. McWhirt, MD, Fulton	Present	Present
GRAVES .....	Charles E. Bea, MD, Mayfield	Present	Present
	Patricia S. Elliott, MD, Mayfield	Present	Present
HICKMAN .....	Bruce C. Smith, MD, Clinton	Present	Present
LIVINGSTON .....	Stephen Burkhardt, MD, Salem	Present	Present
MCCRACKEN .....	Francis J. Block, III, MD, Paducah	Present	Present
	Peter E. Locken, MD, Paducah	Present	Present
	Charles B. Ross, MD, Paducah	Present	Present
	Carolyn S. Watson, MD, Paducah	Present	Present
MARSHALL .....			

#### SECOND DISTRICT

DAVIESS .....	Gerold G. Edds, MD, Owensboro	Present	Present
	Christopher J. Hoveldo, MD, Owensboro	Present	Present
	John D. Loucks, MD, Owensboro	Present	Present
	William Carl Modouss, MD, Owensboro	Present	Present
	Wotten Medley, Jr, MD, Owensboro	Present	Present
	Robert H. Schell, MD, Owensboro	Present	Present
	William L. Tyler, III, MD, Owensboro	Present	Present
HANCOCK .....			
HENDERSON .....	John S. Cave, MD, Henderson	Present	Present
	Marcia L. Cave, MD, Henderson	Present	Present
	Marshall Howell, III, MD, Henderson	Present	Present
MCLEAN .....			
OHIO .....	Eric A. Norsworthy, MD, Hartford	Present	Present
UNION .....	Wallis N. Bell, MD, Morganfield	Present	Present
WEBSTER .....			

#### THIRD DISTRICT

CALDWELL .....	James C. King, Jr, MD, Hopkinsville	Present	Present
CHRISTIAN .....			
CRITTENDEN .....			
HOPKINS .....	Iyad A. Al-Jabi, MD, Modisoville	Present	Present
	Wollice R. Alexander, MD, Madisanville	Present	Present
	James M. Bawles, MD, Madisanville	Present	Present
	Uday V. Dave, MD, Modisoville	Present	Present
	Mohon K. Roo, MD, Modisoville	Present	Present
LYON .....			
MUHLBERG .....	James S. Brashear, MD, Central City	Present	Present
TODD .....			
TRIGG .....			

#### FOURTH DISTRICT

BRECKINRIDGE .....			
BULLITT .....			
GRAYSON .....	Arthur J. McLoughlin, II, MD, Leitchfield	Present	Present
	William L. Shuffett, MD, Greensburg	Present	Present
GREEN .....	Arvil G. Collett, MD, Hodgenville	Present	Present
HARDIN .....	William C. Nash, MD, Elizabethtown	Present	Present
	Mahendra Patel, MD, Elizabethtown	Present	Present
	Jeffrey B. Richardson, MD, Elizabethtown	Present	Present
	Dovid J. Zoeller, MD, Elizabethtown	Present	Present
HART .....	James W. Middleton, Jr, MD, Munfardville	Present	Present
LARUE .....			
MARION .....	Richard L. Litt, MD, Lebanon	Present	Present
MEADE .....	Raymond L. Mathis, DO, Brandenburg	Present	Present



NELSON .....	Lloyd A. Manchikes, MD, Bardstawn	.....	.....
TAYLOR .....	Eugene H. Shively, MD, Campbellsville	Present	Present
WASHINGTON...	Brian F. Wells, MD, Springfield	Present	Present

#### FIFTH DISTRICT

JEFFERSON .....	Jannice O. Aaran, MD, Louisville	.....	.....
	David T. Allen, MD, Louisville	.....	Present
	Kenneth C. Anderson, MD, Louisville	.....	Present
	Joseph C. Banis, Jr, MD, Louisville	.....	.....
	Susan M. Berberich, MD, Louisville	.....	Present
	S. J. Bertalane, Jr, MD, Louisville	.....	.....
	David H. Bizat, MD, Louisville	.....	Present
	Susan G. Bornstein, MD, Louisville	.....	Present
	C. Matthew Brawn, MD, Louisville	.....	.....
	Gregory L. Brawn, MD, Louisville	.....	.....
	Wm. C. Buschemeyer, Jr, MD, Louisville	.....	Present
	David E. Bybee, MD, Louisville	Present	Present
	Peter C. Campbell, MD, Louisville	.....	.....
	Dann R. Chatham, MD, Louisville	.....	.....
	Peter M. Canway, MD, Louisville	.....	.....
	Deborah L. Capeland, MD, Louisville	Present	.....
	Warren Cax, IV, MD, Louisville	.....	Present
	Frederick Cressman, Jr, MD, Louisville	.....	.....
	Jahn H. Doyle, MD, Louisville	Present	Present
	Michael J. Edwards, MD, Louisville	.....	Present
	Rudy J. Ellis, Jr, MD, Louisville	.....	Present
	Jahn M. Farmer, MD, Louisville	.....	.....
	Marjorie R. Fitzgerald, MD, Louisville	.....	.....
	Gary L. Fuchs, MD, Louisville	.....	Present
	Hayt D. Gardner, MD, Louisville	.....	Present
	Katherine P. Garrison, MD, Louisville	Present	Present
	Linda H. Gleis, MD, Louisville	.....	Present
	Leonard A. Gaddy, MD, Louisville	.....	Present
	Lawrence G. Goldberg, MD, Louisville	.....	.....
	Manual Grimaldi, MD, Louisville	.....	Present
	Kathleen C. Harter, MD, Louisville	.....	.....
	B. Thomas Harter, Jr, MD, Louisville	.....	Present
	Jayne L. Hallander, MD, Louisville	Present	.....
	Anna K. Huang, MD, Louisville	.....	Present
	Jahn G. Hubbard, MD, Louisville	.....	.....
	Walter I. Hume, Jr, MD, Louisville	Present	Present
	Arthur H. Isaacs, MD, Louisville	.....	Present
	Barbara Sue Isaacs, MD, Louisville	.....	Present
	Sheri A. Kalbfleisch, MD, Louisville	.....	.....
	Jahn M. Kariba, MD, Louisville	.....	Present
	Stephen S. Kirzinger, MD, Louisville	Present	Present
	Donald R. Kmetz, MD, Louisville	.....	Present
	Gerald M. Larsan, MD, Louisville	.....	.....
	Michael T. Macfarlane, MD, Louisville	.....	Present
	Russell T. May, MD, Louisville	.....	Present
	Maria Maya, MD, Louisville	.....	.....
	James E. McKiernan, Jr, MD, Louisville	.....	Present
	Frank B. Miller, MD, Louisville	Present	Present
	Cathleen J. Marris, MD, Louisville	.....	.....
	Ralph C. Marris, MD, Louisville	.....	Present
	Richard R. Marris, MD, Louisville	.....	.....
	Thomas G. O'Daniel, Jr, MD, Louisville	.....	Present
	Vaughn W. Payne, MD, Louisville	.....	Present
	Habert L. Pence, MD, Louisville	.....	Present
	Steve J. Raible, MD, Louisville	.....	Present
	James E. Redman, MD, Louisville	Present	Present
	K. Thomas Reichard, MD, Louisville	.....	.....
	Kailash C. Sabharwal, MD, Louisville	.....	Present
	George Randolph Schradt, MD, Louisville	.....	Present
	George R. Schradt, Jr, MD, Louisville	.....	Present

Edward L. Scafield, MD, Louisville	Present	Present
William C. Templeton, III, MD, Louisville	.....	.....
Alfred L. Thampson, MD, Louisville	Present	Present
Regula J. Tobias, MD, Louisville	.....	Present
Brenda I. Tawnes, MD, Louisville	Present	.....
Stuart Urbach, MD, Louisville	.....	Present
Daniel W. Varga, MD, Louisville	.....	Present
Gary C. Vitale, MD, Louisville	.....	Present
Henry J. Walter, MD, Louisville	.....	Present
Nartan G. Waterman, MD, Louisville	.....	.....
David R. Watkins, MD, Louisville	.....	.....
Samuel D. Weakley, MD, Louisville	.....	Present
Russell A. Williams, MD, Louisville	.....	Present
James Anthony Wright, MD, Louisville	Present	Present
Janet Wygal, MD, Louisville	.....	.....
C. Milton Young, III, MD, Louisville	Present	Present
George H. Zenger, MD, Louisville	.....	Present

#### SIXTH DISTRICT

ADAIR .....	Richard Lenaghan, MD, Calumbia	Present	Present
ALLEN .....	Jahn M. Hall, MD, Scattsville	.....	.....
BARREN .....	Warren J. Eisenstein, MD, Glasgow	.....	.....
	Melissa Waltan-Shirley, MD, Glasgow	.....	.....
BUTLER .....	Richard T. Wan, MD, Margantawn	.....	.....
CUMBERLAND .....	Joseph D. Skipwarth, MD, Burkesville	.....	.....
EDMONSON .....	Omkar N. Bhatt, MD, Brawnsville	.....	.....
LOGAN .....	.....	.....	.....
METCALFE .....	Lawrence P. Embertan, MD, Edmantan	.....	.....
MONROE .....	James E. Carter, MD, Tampkinsville	.....	.....
SIMPSON .....	Michael Pulliam, MD, Franklin	Present	Present
WARREN .....	James F. Beatie, Jr, MD, Bowling Green	.....	Present
	Jahn T. Burch, MD, Bowling Green	Present	Present
	Robert J. Emslie, MD, Bowling Green	Present	Present
	Timothy K. Hulsey, MD, Bowling Green	.....	.....

#### SEVENTH DISTRICT

ANDERSON .....	Kenneth E. Hines, MD, Lawrenceburg	.....	.....
CARROLL .....	Frank Frast Palmer, MD, Carralltan	Present	.....
FRANKLIN .....	Robert L. Caudill, MD, Frankfort	.....	Present
	Jahn M. Patterson, MD, Frankfort	.....	Present
	William F. Threlkeld, MD, Frankfort	.....	Present
GALLATIN .....	Benjamin Kutnicki, MD, Warsaw	Present	Present
GRANT .....	.....	.....	.....
HENRY .....	James R. Smith, MD, Shelbyville	.....	.....
OLDHAM .....	Harald F. Funke, MD, Crestwood	.....	.....
OWEN .....	.....	.....	.....
SHELBY .....	Ranald E. Waldrige, MD, Shelbyville	.....	.....
SPENCER .....	Thomas C. Crain, MD, Taylarsville	.....	.....
TRIMBLE .....	.....	.....	.....

#### EIGHTH DISTRICT

BOONE .....	Robert L. Baker, Jr, MD, Crescent Springs	Present	Present
	Michael L. Rabinsan, MD, Cavingtan	.....	Present
	Chris Wang, MD, Union	.....	Present
CAMPBELL .....	James L. Evans, III, MD, Fort Thomas	Present	Present
	Steven L. Willett, MD, Fort Thomas	.....	.....
	Steven M. Woodruff, MD, Florence	.....	Present
KENTON .....	Gardan W. Air, MD, Crestview Hills	Present	Present
	Elbert D. Baldrige, Jr, MD, Cavingtan	Present	Present
	Thomas E. Bunnell, MD, Erlanger	Present	Present
	Mark A. Cepela, MD, Edgewood	.....	.....
	Joseph C. Martin, MD, Erlanger	.....	Present

Ross McHenry, MD, Covington	Present	
George E. Miller, MD, Crescent Springs	Present	
Theodore H. Miller, MD, Edgewood	Present	Present
Richard E. Pork, MD, Covington	Present	Present
John F. Sacco, MD, Covington		Present
Marguerite S. Schobell, MD, Florence		
B. Robert Schwartz, MD, Edgewood		Present

#### NINTH DISTRICT

BATH.....			
BOURBON.....	Emmett Lee Tote, MD, Paris	Present	Present
BRACKEN.....			
FLEMING.....	Glenn R. Womock, MD, Flemingsburg		
HARRISON.....	Donald R. Stephens, MD, Cynthiano	Present	Present
MASON.....	Leroy Shouse, MD, Moysville		
NICHOLAS.....			
PENDLETON.....	Robert L. McKenney, MD, Falmouth	Present	Present
ROBERTSON.....			
SCOTT.....	John M. Bennett, MD, Georgetown	Present	Present

#### TENTH DISTRICT

FAYETTE.....	James W. Baker, MD, Lexington	Present	Present
	James R. Beon, MD, Lexington	Present	Present
	David J. Benemo, MD, Lexington	Present	Present
	John V. Barders, MD, Lexington		Present
	Kathleen J. Bas, MD, Lexington		Present
	Terry David Clork, MD, Lexington	Present	Present
	John W. Collins, MD, Lexington	Present	Present
	W. Lisle Dalton, MD, Lexington	Present	Present
	Elvis S. Donaldson, Jr, MD, Lexington	Present	Present
	Richard D. Floyd, IV, MD, Lexington	Present	Present
	Carol L. Fowler, MD, Lexington		Present
	John M. Fox, MD, Lexington		Present
	Joseph E. Gerhordstein, MD, Lexington	Present	Present
	Bill H. Horris, MD, Lexington	Present	
	Richard F. Hench, MD, Lexington	Present	Present
	Roleigh O. Jones, MD, Lexington		
	Dennis B. Kelly, MD, Lexington	Present	Present
	Daniel E. Kenody, Sr, MD, Lexington	Present	Present
	John M. Moore, MD, Lexington		Present
	William N. Offutt, IV, MD, Lexington	Present	
	Charles L. Popp, MD, Lexington		Present
	Borboro A. Phillips, MD, Lexington	Present	Present
	John W. Poundstone, MD, Lexington	Present	Present
	Not H. Sandler, MD, Lexington	Present	Present
	Glenn R. Sheorer, MD, Lexington	Present	Present
	Thomas K. Slobaugh, MD, Lexington	Present	
	David B. Stevens, MD, Lexington	Present	Present
	John D. Stewart, MD, Lexington	Present	Present
	John Robert White, MD, Lexington	Present	Present
	Emery A. Wilson, MD, Lexington	Present	Present
	William O. Witt, MD, Lexington	Present	Present
	T. Allen Woodward, MD, Lexington	Present	
JESSAMINE.....			
WOODFORD.....	C. Dole Goodin, MD, Versailles		

#### ELEVENTH DISTRICT

CLARK.....			
ESTILL.....	John A. Potterson, MD, Irvine		Present
JACKSON.....			
LEE.....	James B. Noble, MD, Beattyville		
MADISON.....			
MENIFEE.....			
MONTGOMERY..	Richard A. Holl, MD, Mount Sterling	Present	
OWSLEY.....			
POWELL.....	Charles G. Noss, MD, Stanton		
WOLFE.....	Wollock L. Post, Jr, MD, Compton		

#### TWELFTH DISTRICT

BOYLE.....	Brion E. Ellis, MD, Donville		
	David C. Liebschutz, MD, Donville	Present	Present
	Arthur K. Rivord, MD, Donville	Present	Present
CASEY.....	Lewis E. Wesley, MD, Liberty	Present	Present
CLINTON.....	Michael Lee Cummings, MD, Albony		
GARRARD.....	Poul J. Sides, MD, Lancaster	Present	Present
LINCOLN.....	C. Glen Click, MD, Stonford		
MCCREARY.....			
MERCER.....	George W. Noe, MD, Harrodsburg	Present	Present
PULASKI.....	Kholid Iqbal, MD, Somerset	Present	Present
	Billy Joe Porson, MD, Somerset	Present	Present
	Joseph G. Weigel, MD, Somerset	Present	Present
ROCKCASTLE.....	William D. Dooley, MD, Mount Vernon		
RUSSELL.....	H. Michael Oghio, MD, Russell Springs		
WAYNE.....	Edward Joseph, MD, Monticello	Present	Present

#### THIRTEENTH DISTRICT

BOYD.....	Poul W. Craig, II, MD, Ashland	Present	Present
	Maurice J. Ockley, MD, Ashland	Present	Present
	John R. Potter, MD, Ashland	Present	Present
	Susan Hess Prosher, MD, Ashland	Present	Present
	Charles T. Watson, MD, Ashland	Present	Present
	Donte R. Oreto, MD, Grayson	Present	Present
CARTER.....			
ELLIOTT.....	John O. Jones, MD, Flatwoods	Present	
GREENUP.....	Lourente B. Tigos, MD, Russell		
	Michael Provetz, MD, Louiso	Present	
LAWRENCE.....			
LEWIS.....			
MORGAN.....	George R. Bellomy, MD, West Liberty		
ROWAN.....	Alon T. Mong, MD, Morehead	Present	Present

#### FOURTEENTH DISTRICT

BREATHITT.....			
FLOYD.....	Nicholas R. Jurich, MD, Prestonsburg	Present	Present
	Roghu R. Sundorum, MD, Mortin		
	Franklen K. Belhosen, MD, Pointsville		
JOHNSON.....			
KNOTT.....			
LETCHER.....	Von S. Breeding, MD, Whitesburg		
MAGOFFIN.....	Charles E. Hordin, Jr, MD, Solyersville		Present
MARTIN.....	Raymond Wells, MD, Inez		
PERRY.....	Gilroy Lone Doley, MD, Hozord		
	David Krosnopolsky, MD, Hozord		
PIKE.....	Boretto R. Cozey, MD, Pikeville	Present	Present
	Lelo C. Moynord, MD, Pikeville	Present	Present
	Charles G. Nichols, MD, Pikeville	Present	Present

#### FIFTEENTH DISTRICT

BELL.....	Meredith J. Evons, MD, Middlesboro	Present	Present
	Shawn S. Fugate, MD, Pineville	Present	
CLAY.....	William E. Becknell, MD, Monchaster		
HARLAN.....	F. Andrew Morfesis, MD, Horlon		Present
	Milo H. Schosser, MD, Benhom	Present	Present
KNOX.....	Horold L. Bushey, MD, Barbourville	Present	Present
LAUREL.....	David W. Douglas, MD, London	Present	Present
LESLIE.....	Roy Vorghese, MD, Hyden		
WHITLEY.....			

#### KMA Hospital Medical Staff Section

William D. Prott, MD, London	Present	
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#### KMA Resident Physicians Section

Judy M. Linger, MD, Georgetown	Present	Present
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#### KMA Student Section

John Bruner, Lexington		Present
Mott McDonald, Louisville		

The information in the roll call was taken from the attendance record cards signed by the delegates prior to the meetings of the House, September 18 and September 20.





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Louisville, KY 40222-8512

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Louisville, KY 40222-8512

Managing Editor (Name and Complete Mailing Address)  
D. Sue Tharp  
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Louisville, KY 40222-8512

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Full Name	Complete Mailing Address
Kentucky Medical Association	301 N. Hurstbourne Parkway, Suite 200 Louisville, KY 40222-8512

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Full Name	Complete Mailing Address
None	

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☐ Has Changed During Preceding 12 Months  
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*D. Sue Tharp, Managing Editor* Date *9-28-95*

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including multiple damages and civil penalties)



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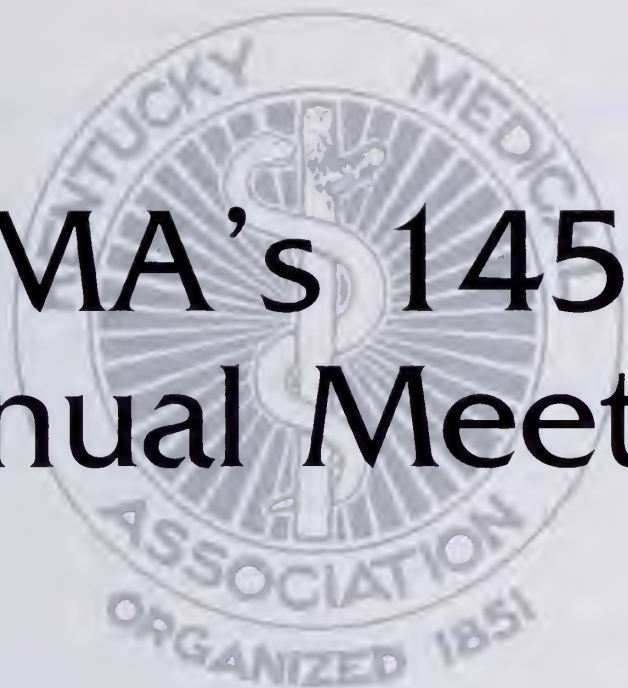
**THE MORE YOU HELP  
THE LESS THEY HURT.**

**1-800-CHILDREN**

National Committee to Prevent Child Abuse



# KMA's 145th Annual Meeting







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## Reference Committees

**S**pecial appreciation to the Chairs and members of the Reference Committees for working so diligently to study committee reports, resolutions, and make recommendations to the full House of Delegates.



(L to R) Reference Committee 1: D. Lee Copeland, MD, Louisville; Jahn M. Patterson, MD, Frankfort; Susan Berberich, MD, Louisville, Chair; John D. Stewart, II, MD, Lexington; Robert Emslie, MD, Bowling Green; John V. Borders, MD, Lexington.



Reference Committee 2: Thomas K. Slabaugh, MD, Lexington; John S. Cave, MD, Henderson; Barbara A. Phillips, MD, Lexington; Baretta R. Casey, MD, Pikeville, Chair; Frank B. Miller, MD, Louisville; William D. Pratt, MD, London.



Reference Committee 3: Charles T. Watson, MD, Ashland; Brenda I. Townes, MD, Louisville; Joseph H. Harpale, Jr, MD, Henderson; Thomas E. Bunnell, MD, Erlanger, Chair; Caralyn S. Watson, MD, Paducah; David W. Douglas, MD, Landan.



Reference Committee 4: Jahn S. Bruner, MSS, Lexington; David J. Bensema, MD, Lexington; W. Fard Threlkeld, MD, Frankfort; Joseph G. Weigel, MD, Samersset, Chair; Jahn R. White, MD, Lexington. Susan G. Bornstein, MD, Luisville, was nat available for the phata.



Reference Cammittee 5: Elvis S. Donaldsan, Jr, MD, Lexington; Judy M. Linger, MD, Georgetown; James F. Beattie, Jr, MD, Bowling Green; Nicholas R. Jurich, MD, Prestansburg; Daniel W. Varga, MD, Louisville; Susan H. Prasher, MD, Ashland, Chair.

# The John James Moren, MD Memorial Meeting of the Kentucky Medical Association

*\*Digest of Proceedings of the Regular Session of the*

## House of Delegates

*C. Kenneth Peters, MD, Jeffersontown*

*Speaker of the House*

*John W. McClellan, MD, Henderson*

*Vice Speaker of the House*

*Presiding*

### First Meeting September 18, 1995

**C** Kenneth Peters, MD, Speaker of the KMA House of Delegates, called the first Meeting of the 145th Session of the House of Delegates to order at 9:00 AM on Monday, September 18, 1995, at the Hyatt Regency Hotel, Lexington, Kentucky. He introduced the Vice Speaker, John W. McClellan, MD, and KMA's Legal Counsel, Charles J. Cronan, IV, Louisville.

Following the invocation given by Harold L. Bushey, MD, Barbourville, the Chair of the Credentials Committee, C. R. Dodds, MD, Earlington, reported that a quorum was present. A motion was made, seconded, and carried to approve the Minutes of the 1994 Session of the House of Delegates as published in the December 1994 *Journal of the Kentucky Medical Association*.

William P. VonderHaar, MD, Louisville, Secretary-Treasurer, announced that the Scientific Session would begin at 8:50 AM on Tuesday, September 19, and the President's Luncheon would be held on Wednesday, September 20, at which time the new President would be installed. Dr VonderHaar reminded the Delegates that Reference Committees would convene at 1:00 PM on Monday. He then asked the House members to stand for a moment of silence in memory of KMA members who had died since the 1994 Annual Meeting.

Speaker Peters announced that the Rules Committee had prepared a booklet outlining the rules the House should follow in its deliberations.

Robert R. Goodin, MD, President, presented the Educational Achievement Award to Frank B. Miller, MD, Louisville; and the Chair of the Awards Committee, Ardis D. Hoven, MD, presented Peter P. Bosomworth, MD, Lexington, with the Distinguished Service Award for 1994, as he had been out of the country when last year's presentation was made. Joyce Clark, Somerset, immediate past president of the KMA Alliance, presented AMA-ERF checks comprised of funds the Alliance

had raised to benefit Kentucky's medical schools. Emery A. Wilson, MD, Dean, accepted a check in the amount of \$15,852.44 on behalf of the University of Kentucky College of Medicine; and Alfred L. Thompson, MD, Associate Vice President for Hospital Affairs, accepted a check for \$23,948.06 on behalf of the University of Louisville School of Medicine.

Dr Peters noted that four "tribute" Resolutions had been introduced. The Resolutions were read, and a motion was made, seconded, and carried to adopt each as written.

### Women in Medicine Month KMA Board of Trustees

WHEREAS, historically women did not have access to formal medical education in the United States until the mid-19th century, but now comprise more than 40% of all medical students; and

WHEREAS, the number of women in medicine is continuing to increase, with nearly 20% of all US physicians now being female, and projections that, by the year 2010, women will represent one-third of all physicians; and

WHEREAS, in Kentucky there are over 1,300 women physicians either in practice or in residency training, representing 20% of all Kentucky physicians; and

WHEREAS, women now represent a vital force in the medical profession and hold key leadership positions in organized medicine, medical education, public health, and government; and

WHEREAS, Kentucky is fortunate to have a growing number of women physicians and women physicians in training serving in leadership roles in KMA; and

WHEREAS, the American Medical Association has declared September as Women in Medicine Month; therefore, be it

RESOLVED, that the Kentucky Medical Association recognizes the commitment, dedication, and accomplishments of women physicians and hereby declares September, Women in Medicine month.

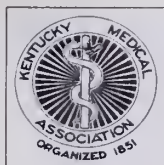
### Tribute to James B. Holloway, Jr, MD KMA Board of Trustees

WHEREAS, James B. Holloway, Jr, MD, has served the medical profession and this Association with distinction and diligence for over 40 years; and

WHEREAS, this service has included terms as Trustee, Chairman of the

**\*Editorial Note: A tape recording was made of the two meetings of the House of Delegates, and any member who wishes to examine the transcript of these Proceedings may visit the Headquarters Office and listen to the recordings.**





Board, and President of the Kentucky Medical Association, as well as numerous committee and chair positions; and

WHEREAS, Doctor Holloway has brought to his public and professional duties a unique and effective blend of succinctness, candor, and equity; and

WHEREAS, Doctor Holloway has announced his retirement as Medical Director of the Medicare program in Kentucky; now, therefore, be it

RESOLVED, that this House of Delegates recognizes James B. Holloway, Jr, MD, for his distinguished dedication to the medical profession and the dignity and selflessness he has consistently displayed in his efforts; and be it further

RESOLVED, that this resolution be presented to Doctor Holloway with the esteem and gratitude of his peers and this Association, along with sincerest best wishes for all his future endeavors; and be it further

RESOLVED, that this document be recorded as a permanent portion of the proceedings of this House of Delegates.

#### **Tribute to Russell L. Travis, MD**

##### **KMA Board of Trustees**

WHEREAS, Russell L. Travis, MD, has served as Chair of the Kentucky Physicians Care Program since it began operations January 1, 1985, and;

WHEREAS, during the past 11 years, 135,600 calls have been made to the toll-free number and over 55,000 referrals representing an estimated 220,000 physician encounters have occurred at no charge to the patient; and

WHEREAS, Kentucky Physicians Care was the only program of its kind when it began, but has since been duplicated by other state and local medical organizations; and

WHEREAS, Kentucky Physicians Care has brought positive national, state, and local recognition to the Kentucky Medical Association, as well as to individual physicians and their communities; and

WHEREAS, Kentucky Physicians Care was chosen as the first recipient of the AMA President's Citation for Service to the Public in 1988; received an Award of Excellence from Associations Advance America; and was honored with the President's Program for Private Sector Initiatives by President Ronald Reagan in 1986; and

WHEREAS, initial participants in the project, the Kentucky Medical Association, the Kentucky Hospital Association, and the Kentucky Health Care Access Foundation have now been joined by the Kentucky Dental Association, the Kentucky Association of Health Care Facilities, the Kentucky Home Health Association, Hospice, the Kentucky Pharmacists Association, and several major pharmaceutical manufacturers, all of which provide free services and products to eligible KPC patients; and

WHEREAS, Russell L. Travis, MD, in his capacity as Chair of the Kentucky Physicians Care Operating Committee continues to champion the ideal of access to care by all citizens of the Commonwealth; and

WHEREAS, Russell L. Travis, MD, has not only made extraordinary efforts to encourage physician participation in KPC, but has given freely of his time and expertise as a participating provider in Kentucky Physicians Care; now therefore, be it

RESOLVED, that the KMA House of Delegates does hereby recognize, commend, and express its appreciation to Russell L. Travis, MD, for his devotion to helping those less fortunate citizens of the Commonwealth.

#### **Tribute to Mr Gerald Swim**

##### **KMA Board of Trustees**

WHEREAS, Mr Gerald Swim has given his time and energy for over 20 years to improve the level of continuing medical education in Kentucky; and

WHEREAS, this service has included invaluable input to the Council on Continuing Medical Education and the Continuing Medical Education Committee, as well as serving on numerous CME site survey teams for the Association; and

WHEREAS, Mr Swim has sustained his professional acumen with unending energy, expedient counsel, and forthrightness; and

WHEREAS, Mr Swim has announced his retirement as Director of Continuing Medical Education at the University of Louisville; now, therefore, be it

RESOLVED, that this House of Delegates recognizes Mr Gerald Swim for his outstanding service to the medical community and the dignity and dedication he has consistently brought to all his efforts; and be it further

RESOLVED, that this resolution be presented to Mr Swim with best wishes for all his future endeavors; and be it further

RESOLVED, that this document be recorded as a permanent portion of the proceedings of this House of Delegates.

Dr Peters introduced the officers who presented their Reports. Each of the Reports was assigned to a Reference Committee as noted:

Report Number		Reference Committee
1	Report of the President	1
2	Report of the President, KMA Alliance	1
3	Report of the President-Elect	1
4	Report of the Speakers, House of Delegates	1
5	Report of the Chair, Board of Trustees	1
6	Report of the Secretary-Treasurer	1
7	Report of the Editor	1
8	Report of the Delegates to AMA	1
9	Report of the Executive Vice President	1
10	Report of the KMA Physicians Services, Inc	1
11	Report of the Kentucky Medical Insurance Company	1
12	EMCK Foundation	1
13	Report of the Physician Advisory Committee to Health Kentucky	1
14	Scientific Program Committee	2
15	Scientific Exhibits Committee	2
16	Continuing Medical Education Committee	2
17	Council for Continuing Medical Education	2
18	Cancer Committee	2
19	Physician Workforce Committee	2
20	Hospital Medical Staff Section	2
21	Rural Kentucky Medical Scholarship Fund	2
22	Maternal Mortality Study Committee	3
23	Committee on National Legislative Activities	3
24	Committee on State Legislative Activities	3
25	Committee on Professional Liability Insurance	3
26	Committee on Care of the Elderly	3
27	Public Education Committee	3
28	Committee on Medical Insurance and Prepayment Plans	4
29	Committee on Claims and Utilization Review	4
30	PRO Advisory Committee	4
31	Committee to Investigate Changing Trends in Medicine	4
32	Physician Organization Study Committee	4
33	Young Physicians Steering Committee	4
34	Resident Physicians Section	4
35	Medical Student Section	4
36	Committee on Maternal and Neonatal Health	5
37	Technical Advisory Committee on Physician Services (Medicaid)	5
38	Committee on Community and Rural Health	5
39	Committee on Physical Education and Medical Aspects of Sports	5
40	Committee on Child and School Health	5
41	Judicial Council	5

## **New Business**

New Business of the House was assigned to the Reference Committee indicated:

Resolution	Submitted by	Subject	Reference Committee
A	Board of Trustees	Privatization of Medicaid	5
B	Board of Trustees	Medicaid Block Grant Funding	5
C	Board of Trustees	Medicaid Managed Care	5
D	Board of Trustees	Insurance Coverage for Obstetrical Care	4
E	Fayette County Medical Society	Youth Access to Tobacco Products	3
F	Fayette County Medical Society	Statewide Health Information Network	4
G	Board of Trustees	Board Authority for Any KMIC Restructuring	1
H	Board of Trustees	Patient Protection and Preservation of Choice	4
I	Jefferson County Medical Society	Reaffirming Provider Tax Opposition	3
J	Jefferson County Medical Society	Provision for Decision to Withhold Futile Medical Intervention by State-Appointed Guardianship Services	3
K	Jefferson County Medical Society	Advance Directive Forms	2

L	Jefferson County Medical Society	Standard Physician's Service Agreement	4
M	Young Physicians Section	Socioeconomic Curricula for In-Training Physicians	2
N	Warren County Medical Society	Provider Tax	3
O	Warren County Medical Society	Robert Wood Johnson Foundation's Interference in Kentucky State Government	3
P	Warren County Medical Society	Release of Patient Information to the Health Policy Board	1
Q	Estill County Medical Society	Kentucky Organic Growers	2
R	Fayette County Medical Society	Optometrists as Primary Care Providers	2
S	Floyd County Medical Society	Medicaid Reimbursement	5
T	Thomas M. Adams, MD	Physician Assistants	1
U	Pulaski County Medical Society	Insurance Coverage for Obstetrical Care	4
V	Charles E. Hardin, MD	Medicaid Funding	5

Vice Speaker McClellan announced the meeting locations for the Nominating Committee and for Trustee Districts electing Trustees and Alternate Trustees. He reminded the Delegates that the Nominating Committee would report at the close of the first Scientific Session on Tuesday morning.

The names of the Nominating Committee members were announced: James R. Bean, MD, Lexington, Chair; James D. Crase, MD, Somerset; Joe T. Davis, MD, Bowling Green; Jayne L. Hollander, MD, Louisville; and Michelle M. Murray, MD, Alexandria.

President Goodin introduced Daniel H. Johnson, MD, President-Elect of the American Medical Association, who delivered an address which included a review of AMA's proposed Medicare program.

The Vice Speaker adjourned the First Meeting at 11:00 AM.

## Second Meeting September 20, 1995

C. Kenneth Peters, MD, Speaker, House of Delegates, called the Second Meeting of the 1995 Session of the KMA House of Delegates to order at 7:00 PM on Wednesday, September 20, 1995.

Barbara Phillips, MD, Lexington, gave the Invocation, and C. R. Dodds, MD, Earlington, Chair of the Credentials Committee, reported that a quorum was present.

Secretary-Treasurer VonderHaar recognized guests from neighboring state medical associations who had attended the Annual Meeting. Included were Russell D. Evett, MD, President of the Medical Society of Virginia; Jack L. Summers, MD, President, Ohio State Medical Association; James D. Helsley, MD, President, West Virginia State Medical Association; Raymond E. Hoffmann, MD, President, Illinois State Medical Society; and Peter Winters, MD, Speaker, House of Delegates, Indiana State Medical Association.

Don R. Stephens, MD, Chair, Board of Trustees, made a motion on behalf of the Board that Charles R. Sachatello, MD, Lexington, be reelected to a four-year term on the Judicial Council. The motion was seconded from the floor and carried.

Richard F. Hench, MD, Lexington, Chair of the Kentucky Medical Insurance Company Board of Directors, presented an update on Kentucky Medical's status and activities. Preston P. Nunneley, MD, Chair of the KMA Public Education Committee, showed a video relating to the committee's activities.

The Speaker then called for the Reference Committee Chairs to present their Reports.

**Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.**

## REPORT OF REFERENCE COMMITTEE NO. 1

**Susan M. Berberich, MD, Louisville, Chair**

1. Report of the President
  2. Report of the President, Alliance
  3. Report of the President-Elect
  4. Report of the Speakers, House of Delegates
  5. Report of the Chair, Board of Trustees
  6. Report of the Secretary-Treasurer
  7. Report of the Editor
  8. Report of the Delegates to AMA
  9. Report of the Executive Vice President
  10. Report of KMA Physicians Services, Inc
  11. Report of the Kentucky Medical Insurance Company
  12. Report of the EMCK Foundation
  13. Report of the Physician Advisory Committee to Health Kentucky
- Resolution G — Board Authority for Any KMIC Restructuring (Board of Trustees)
- Resolution P — Release of Patient Information to the Health Policy Board (Warren County Medical Society)
- Resolution T — Physician Assistants (Thomas M. Adams, MD)

## ITEMS FOR CONSENT

Reference Committee No. 1 reviewed the following items and recommends they be filed, by consent of the House, without discussion:

1. Report of the President — filed
2. Report of the President, Alliance — filed
3. Report of the President-Elect — filed
4. Report of the Speakers, House of Delegates — filed
5. Report of the Chair, Board of Trustees — filed
6. Report of the Secretary-Treasurer — filed
7. Report of the Editor — filed
8. Report of the Delegates to AMA — filed
9. Report of the Executive Vice President — filed
10. Report of KMA Physicians Services, Inc — filed
11. Report of the Kentucky Medical Insurance Company — filed
12. Report of the EMCK Foundation — filed

Mr Speaker, Reference Committee No. 1 thanks these officers and committees for their efforts and recommends adoption of the Consent Calendar as a whole.

## Report of the President

The 1994-95 Kentucky Medical Association year has been a very busy one for your elected leadership and the staff of the Kentucky Medical Association. At our House of Delegates meeting in September 1994 you directed us to pursue many goals, and we have worked diligently to accomplish as many of those objectives as possible. The majority of our efforts have been spent in the following areas and, as you will note, many of these remain ongoing projects.

### Medicaid — Issues with HB 250

It quickly became apparent that among the many objectionable sections in HB 250, Medicaid issues would require the most attention. Major commitments, both in litigation and lobbying, have been expended in the area of Medicaid.

- The provider tax was ruled unconstitutional by the Franklin Circuit Court, only to be reversed by the Kentucky State Supreme Court. The US Supreme Court refused to hear the case. As such, the tax remains in place, collecting \$40 million per year from physicians. Our next hope to rid ourselves of this unfair tax is through legislation in the 1996 Kentucky General Assembly. Both the Committee on State Legislative Activities and the Public Education Committee are launching major efforts throughout the state to assist in this challenge.
- The Discount Option Program (DOP) regulations were written, but fortunately, the Administrative Regulations and Review Committee agreed with us unanimously that the regulations did not follow the intent of the legislation, and the DOP will expire April 15, 1996, unless new legislation is passed.
- The Cabinet for Human Resources implemented major reimbursement





cuts to physicians (\$52 million per year) only weeks after HB 250 became law. Judge Joseph Hood agreed with us and issued a permanent injunction against implementation. However, the Sixth Circuit Court of Appeals stayed the injunction, and we await its ruling as a result of an appeal filed by the Cabinet for Human Resources. In the meantime, the Administrative Regulations and Review Committee did agree with us that the cuts were outside the intent of the legislation. Regardless of the Sixth Circuit Court ruling, the reimbursement cuts will expire April 15, 1996, unless new legislation is introduced and passed.

#### HB 250

A second major area requiring our careful attention and a great commitment of time lies within the many aspects of HB 250. These areas included: the Kentucky Health Policy Board, Insurance Purchasing Alliance, practice parameters, patient records, Certificate of Need, fee disclosure, and data collection and reporting.

We have carefully monitored the regulations on several of these items and their implementation as they have been developed and presented, and responded aggressively when we felt the requirements were either punitive to physicians or harmful to our patients. A great number of Kentucky physicians have eagerly agreed to serve in several capacities, especially on committees regarding practice parameters, and those efforts are greatly appreciated. On many occasions, we have been able to effect significant changes in regulations to the benefit of our patients. Several legislators are writing bills at this time to be introduced in the 1996 Kentucky General Assembly which, if passed, will result in major changes in many sections of HB 250. Your Legislative Committee will require enormous commitments by Kentucky physicians as we enter the 1996 session.

#### Legislation and Public Education

At the 1995 KMA House of Delegates meeting, we will present several resolutions for discussion, and we must carefully determine our legislative priorities for 1996. Among the many topics the board has discussed at length and will present for review are: the provider tax, Discount Option Program, Patient Protection Act, any willing provider, point-of-service legislation, tort reform, Certificate of Need, nonphysician practice of medicine, practice parameters, Medicaid, and managed care.

#### Joint Officer Group (JOG) Meetings with Kentucky Health Policy Board Members

During the year, we sought to meet with individual members of the Health Policy Board (HPB) and associated staff on various items. Although we have reservations about the position and authority of the HPB, as directed by this House of Delegates, your officers were able to represent physicians' concerns in several areas. It is probably safe to say that a valuable working rapport has been established that has not compromised KMA's position on HB 250 issues.

#### Federation Study Participation

This year I was privileged to be selected representative to meet with other elected medical association officers across the country to participate in the Federation Study of the American Medical Association. This study was commissioned by the AMA House of Delegates to analyze the roles of the county, state, specialty, and national associations in furthering the goals of the profession, now and in the future. This is an ongoing effort that will take some time to complete. It is gratifying to know that so many experienced and dedicated people are involved in sustaining and promoting our objectives, and I was honored to play a part.

This report could not be considered complete without addressing major challenges that face physicians in the immediate future, as viewed from serving as your President in 1994-95. I urge you to consider these areas that require major physician commitment of careful consideration, study, and time:

- **Managed Care** — I am convinced the growth of managed care will remain the most important issue that we face over the next several years, even more so than dealing with onerous health system reform legislation. We clearly must anticipate the continued growth of managed care, not only in the private sector, but especially with Medicare and Medicaid. We physicians are the only true advocates that patients can rely on, and it is imperative that we participate at every level in the managed care arena. We absolutely must not allow insurance companies, hospitals, managed care organizations, nor state government to make important patient care

decisions. We physicians are the only ones licensed to practice medicine, certainly the only ones who can determine quality of care issues. It is obvious that the nonphysician managed care folks are interested primarily in cost containment.

- **Legislative Efforts** — Your KMA Committee on Legislative Activities and Public Education Committee are working diligently to assist physicians in becoming well informed regarding important issues in health care. These efforts obviously must be translated into action by physicians. Kentucky physicians participated at an all-time high level in the 1994 Kentucky General Assembly. We have greatly improved our participation in KEM-PAC, but we continue to have far too few physicians participating. If we are to be successful in making significant changes, they will occur through legislation and not by litigation. This success is totally dependent on massive participation by physicians.

- **Leadership** — I am convinced that we have excellent leadership among your trustees, elected leadership at the KMA level, and most importantly, at the delegate level. We must, however, redouble our efforts, and this is especially true at trustee and delegate levels since it is especially important that these physicians take home to their constituents the important information that is being shared at the House of Delegates level. I can see no other way that we can become a very strong and unified body representing the house of medicine and the patients of Kentucky. It is obvious that we all much prefer to spend our time doing what we entered this great profession to do — practice medicine — but our profession is truly at risk at this point in history. These next several transition years in the health care delivery system will be critical to the future of our profession, and it is entirely up to us — you and me — to protect the profession and, in fact, strengthen it in the process. I urge each and every Kentucky physician to not only continue providing excellent care to our patients, but to also commit a significant segment of time and energy to our profession.

This has been a year of hard work and great gratification for me. My only regret is that I couldn't be in more places and involved in more efforts than occurred. I am deeply impressed by the commitment and capabilities of the officers of KMA and have renewed faith in the Board of Trustees and the process of consensus it has followed. Most of all, I am humbled by my reassociation with all physicians across the state in whose trust medical care is routinely and compassionately rendered. I truly value this year of service and truly appreciate the opportunity given me to be your President.

**Robert R. Goodin, MD**  
President

#### Report of the President, Alliance

The focus of the Alliance this year was to continue our efforts against youth violence, an antismoking campaign, and to respond to the legislative needs of the KMA. To accomplish these goals we stressed being united, committed, and involved.

Our membership responded to these goals in many ways, including unified membership in all organized counties and developing a plan to make contact with potential members that reside in unorganized counties. This plan included dividing the state into geographical regions and having an Alliance member serve as a member-at-large (MAL) membership coordinator.

Our leadership worked to contact physician spouses and to invite them to become involved with the mission of the Alliance. They worked throughout the state to project a strong image of medicine and to become more visibly involved in community activities.

The Kentucky Alliance received several honors and awards at the Southern Medical Association Auxiliary Annual Meeting in Orlando in November. These included Doctors' Day Award: 1st place, statewide exhibit; Medical Heritage Award: 1st place, statewide project; and the Dr & Mrs Milford O. Rouse Award: Medical Heritage Award. These honors were received as a result of hard work by our state members.

Our membership and the citizens of Kentucky are very concerned about the violence in our schools and communities. Responding to these concerns, a workshop on "Children at Risk — A Community Challenge" was held at the Fall Meeting. The workshop offered suggestions on programs that could be implemented to affect behavioral problems and violence. Other workshops held at the Fall Meeting included legislation and membership development.



Our 1,000 plus members were active across the state working in coalition with schools, churches, community agencies, civic groups, and independent programs that would impact the future of our youth. In Fayette, two members developed an antismoking program called "SMART." This program has been presented in area schools by Alliance volunteers and has been well received by the school personnel and parents.

Paducah members developed "SECOND STEP," an antiviolence program for fourth and fifth graders dealing with conflict resolution. Pulaski County distributed over 2,500 "I CAN CHOOSE" booklets to kindergarten and primary students, with Alliance members helping with the lessons outlined in these booklets. Alliance volunteers aided in teaching the lessons outlined in these booklets.

Boyd County held an "AIDS" program and a shower for the Shelter of Hope. Owensboro helped with the opening of the Hospitality House, a haven for families of hospitalized patients, and provided furnishings for one room. Hopkins County developed a pilot project entitled, "BARE FACTS ON CHILD HEALTH," a community health education project for parents of preschool children. Jefferson County held a "TRASH AND TREASURE" sale that grossed over \$13,000 to benefit AMA-ERF, Hospitality House, the Healing Place, and other Alliance projects.

All organized counties were busy with fund-raisers to promote and help fund programs in their communities.

The Kentucky Medical Association was supported by Alliance members across the state as members worked to implement grassroots legislative efforts in every organized county. Members-at-Large also became involved in these efforts with phone calls and personal contacts. With the help of Alliance members, a physician was elected to the state Senate. Phone banks were formed in all organized counties and remain in place. Currently, the Alliance members are working to establish a FAX network for KMA. Our Fall Legislative Workshop helped to educate our members on how to speak with our legislators and how to become politically involved. Alliance members are the invisible workers for the Kentucky Medical Association in their health care reform efforts.

The support of the KMA and the positive promotion of the Alliance by the KMA leadership have allowed the Alliance to continue to provide Kentucky physician spouses with quality programs and projects. I appreciate the support and continued encouragement provided by the Kentucky Medical Association leadership and staff as we work together to achieve the mission of the KMA Alliance, "To work in coalition with the KMA to promote quality health care and sound legislation."

Leadership training was available for county and state Alliance leaders by the AMAA Confluences held in Chicago. This leadership training is a valuable tool for county presidents-elect, teaching them new ideas and providing them with invaluable networking with other county and state leaders from across the United States. This year we had members from Boyd, Daviess, Fayette, Jefferson, McCracken, Perry, Hopkins, Pulaski, and Northern Kentucky attend these intense training sessions.

AMAA leadership provided information and assistance to counties in their efforts to increase membership, to raise funds for medical education through AMA-ERF, health promotions programs and projects, and updates on legislative issues.

Monthly newsletters kept our membership informed about activities across the state, activities at the McDowell House, the needs of the Ronald McDonald Houses, and special projects involving medical heritage and Doctors' Day. Our *Bluegrass News* issues provided another means of communication for our members by providing them with reports on the AMA Convention; Fall, Winter, and Spring meeting information; and county and state chairman reports.

Our Spring Convention provided a time for Alliance members to gather in fellowship and fun as well as a time to share projects and accomplishments of the year. At the close of our convention, a fun basket auction was held to benefit the McDowell House. A total of \$1,330.00 was raised to purchase a much needed program for its computer.

Our Alliance was recognized at the AMAA Convention in June for our increase in membership, federated membership, and the organization of Franklin County. We received national recognition for our accomplishments in funds collected for AMA-ERF. These included: 5th greatest per capita — state award; 5th greatest contribution — county award, Boyd County; and 2nd greatest per capita — county award, Boyd County. Our state and county alliances received a certificate of appreciation from James Todd, MD, Execu-

tive Vice President of AMA, for our work and efforts in the legislative arena.

Our AMA-ERF collections for 1994-95 totaled \$58,232.52, an increase of over \$12,394.00.

Physicians' spouses across the Commonwealth of Kentucky are **UNITED, COMMITTED, AND INVOLVED** in our efforts to impact sound health care legislation and programs that will affect the health and well-being of our citizens. We encourage you to help us with our effort by encouraging physician spouses in your communities to join our organization and our efforts.

Joyce Clark  
KMAA President, 1994-95

## Report of the President-Elect

It is my pleasure to report to you as President-Elect. This has been a year of learning and growth for me. I have had the opportunity to serve the Association in various capacities in the past, but this year has provided a unique perspective. I have been able to observe and take part in many policy development and implementation efforts, and have been able to see firsthand how the process works. I can faithfully report that the Association chose well in electing Bob Goodin as your President, and hope I can emulate his energy and dedication. The Board has made an equally good choice in selecting Don Stephens as Chairman, and I have been impressed with the earnest commitment of all members of the Executive Committee.

My observations have been revealing and have defined some directions that physicians in the medical profession should continue to pursue, even more vigorously than in the past. Probably many of us have had the impression that government forces exert an ever-increasing influence on our profession, as they certainly have. But there are some very encouraging signs. There is a strong possibility that the Medicaid Provider Tax will be repealed in the next session of the General Assembly, that some of the more onerous provisions of HB 250 will be modified, and that significant health care reform in the Clinton model is moribund.

It is likely that a large factor influencing these issues was patient freedom of choice. Even though managed care seems to be the catch phrase of the day, it is being questioned by such surprising allies as the Government Accounting Office and the *Wall Street Journal*.

No one questions that many changes in our health care delivery system are probably overdue. It is probably safe to say that legislators have generally responded to the will of the population, and no longer see health care delivery system change as being synonymous with cost control. What has become apparent is that even though medicine has been victimized by government and the legislature, we don't need to be victims, and we truly can have an impact on what happens to us.

We should continue to seek a seat at the table where change is discussed, and I think we will have a say, because I believe the population finds our input appropriate, even though the bureaucracy and the legislature may not.

I see the bulk of our difficulties as being political problems, and so we are going to have to seek political answers. This means, obviously, that we must be part of the political process. Most of us are not. Just as with medicine, the best results come from close contact with our subjects, and this could not be more important than in the legislative process. To this end and to further our goals as a profession, I hope that all county medical societies can meet with their legislators during the months of October and November and continue these contacts throughout the year.

We will be confronted with many legislative challenges in the Kentucky General Assembly, and we will initiate or renew attention on several issues. It seems to me that continued work to restore the Medicaid reimbursement reductions and the pursuit of helpful tort reform are obvious priorities.

As in the past, Board members and officers will be available in the coming year to medical staff meetings and other gatherings of physicians to provide up-to-date information on KMA positions in regard to various legislative issues and to receive input and feedback from the membership.

I feel humbled by the effective efforts and successes of my predecessors and challenged to emulate their work. With your help, I pledge my best efforts.

Danny M. Clark, MD  
President-Elect





## Report of the Speakers, House of Delegates

Greetings from your Speakers, and welcome to the 145th KMA Annual Meeting. Although new in our positions, we bring a strong commitment to serving the House and the individual delegates coming to guide the business of the Association.

It is our intent to continue the process begun last year of modifying the way the House conducts business to involve more young physicians and other subgroups who will be emerging as the spokespersons and leaders in our profession. Again this year there will be five reference committees, and we are attempting to equalize the issues assigned to them so that every delegate can have equally proportional access to the business being conducted. In appointing reference committees, some physicians expressed an early interest in service, and we have made every effort to appoint these individuals. We would invite any members to come forward if they have an interest in participation, and we will make every effort to accommodate them.

As senior members of the profession, both your Speakers are aware of the changing complexion of the profession, and we hope that everyone will join us in encouraging volunteerism by young physicians, women physicians, and minority physicians, as they assume an expanding proportion of medicine.

In the spirit of broadened opportunity, we also seek the help of all delegates and members to make the process of establishing Association policy accessible and open to everyone. We urge delegates to seek us out; let us know your thoughts about changes and how we can better conduct the business of KMA.

In the spirit of expanding focus, we would like to point out that this House of Delegates voted for mandatory participation in continuing medical education tied to licensure. This CME requirement is based on a three-year period ending in April 1997. The requirement for three years is the accumulation of 60 hours of CME credit, 30 hours of which must be in AMA Category 1, and 30 hours in Category 2. This meeting qualifies for 16 hours of AMA Category 1 credit on an hour-per-hour basis, and is also recognized by the Kentucky Chapter, American Academy of Family Physicians. Included in this requirement is a state mandate for 2 hours of CME in HIV-related issues every three years. To this end, a special opportunity has been scheduled for Thursday, September 21, entitled "HIV Update for Physicians" to meet the state requirement, and this session is approved by the Cabinet for Human Resources.

We are fortunate this year to have arranged for the appearance and address by Daniel H. Johnson, Jr, MD, President-Elect of the American Medical Association. Dr Johnson will address the House on Monday morning, September 18, immediately following the close of the first meeting of the House of Delegates.

We continue in a time of complexity and opportunity for medicine. More changes will confront our profession than ever before, and it is vital that delegates come to the meeting prepared to take part in the discussions that will guide our Association for the next year. Your Speakers pledge our cooperation and diligence, and appreciate the honor of being selected to serve.

**C. Kenneth Peters, MD**  
**Speaker, House of Delegates**

**John W. McClellan, MD**  
**Vice Speaker, House of Delegates**

## Report of the Chair, Board of Trustees

### Introductory Comments

The 1994-95 Association year concludes a tumultuous and challenging two years as Chair of your Board of Trustees. These have not been the "best of times" for several reasons. First of all, the fallout from the chaos created by House Bill 250 infiltrates our everyday practice of medicine, erects barriers between us and our patients, and drives a bureaucratic machine that may soon outgrow its nearest state government competitors, the Human Resources and Transportation Cabinets. I have reservations and fears with regard to the growth of the Health Policy Board and its appendages.

Secondly, it seems as if everything we have attempted to do this year

has either involved a lawsuit or making plans for one. The "legal mania" has been extremely invasive and enormously obstructive of many positive actions and has certainly detracted from our true mission. This Association has traditionally served as one of the chief and outspoken voices in Kentucky for reform of the legal system. We have stated time after time that there are better ways to resolve problems and settle disputes. Prior to 1994, the Association had been involved in only one other court case with the Commonwealth since its formation 145 years ago. Quite frankly, we have not been perfectly comfortable in this legal quagmire, even though what we have done — and what we are doing — is correct and in the best interest of our patients and the profession.

While I will not elaborate further on the legal processes and the distraction these barriers have placed in our paths, KMA Counsel Mike Cronan will outline in a separate section of this report the legal events transpiring during this year. Thankfully, there is a "light at the end of a four-year tunnel," and that will occur in December 1995 when a new Governor is inaugurated.

The scattered remnants of House Bill 250 have touched all of our patients and most of our practices. If you have not yet been hassled by some portion of HB 250 or edict from the Health Policy Board, don't despair, you soon will be. The Board of Trustees, Executive Committee, Quick Action Committee, Committee on State Legislative Activities, Public Education Committee, and numerous other entities at KMA have literally been inundated by HB 250's machinations. House Bill 250 is pure and simple legislation intended to harass providers while appearing to help patients. Ostensibly, the goal of health care reform was to address the uninsured population and correct inequities in insurance laws. It would appear that this Governor totally missed his initial objective, and the insurance reforms are actually a product of Senate conservative forces. During the past year, we have established a Joint Oversight Group (JOG) in collaboration with the Kentucky Hospital Association. The KMA/KHA cooperative has met with members of the Health Policy Board to ascertain their goals and plans and in turn, keep our membership fully informed. JOG has also provided us a conduit through which we can present our positions and proposals up-front and provide input prior to the final decision. A bonus in this entire process has resulted from our meetings with KHA officers and executives and the sharing of mutual concerns.

Various portions of HB 250 concern us — some more than others. Among issues directly affecting the profession, in addition to the provider tax and Medicaid reimbursement in which we have been intensively engaged, are: Discount Option Program, state health plan, physician fee disclosure, Certificate of Need, solvency standards for provider entities, practice parameters, standard benefit plans, health purchasing alliance, medical records, and data collection.

The Discount Option Program has been particularly troubling for your Board and we have aggressively attacked the program throughout the administrative and legislative processes. While we almost single-handedly forced the CHR back to the drawing boards, it is still attempting to implement the program despite an obviously flawed piece of legislation. This issue will be a major objective during the 1996 session of the Kentucky General Assembly. DOP, originally entitled "provider of last resort," in HB 250 required the CHR to develop and market a plan "through the Medicaid program." Unfortunately, DOP ended up being a mandatory, rate-setting, bureaucratic boondoggle that would create enormous problems for the people it was originally intended to help — the uninsured.

A second troubling aspect of HB 250 is the development of practice parameters. While I do not intend to go into any depth in this report, development of practice parameters in Kentucky appears to be geared to nothing more than appeasing the CHR and Workers' Compensation — in other words — COST. That was never the intent of practice parameters, and it is our goal to directly address these concerns in the '96 Session.

Thirdly, we grow increasingly irritated with the data collection requirement under HB 250. Originally, health care reform was designed to address the paperwork maze. However, it appears that HB 250 has been the granddaddy of all paperwork factories. These and other issues including "free" medical records concern us, and we are hopeful that the General Assembly will empathize with us on these problems.

Perhaps the most troubling phase in which medicine finds itself is the growth of managed care and a resulting and corresponding grant of power to health insurers. While we do not oppose managed care, we must be watchful and aggressive in stopping growth that infringes on the physician/



patient relationship and our ability to render care within the system. HB 250 obviously favors the insurers in this process.

As most of you are aware, the Board of Trustees "voluntarily assessed" each member of KMA \$100 to fund our Legal Trust Fund deficit. Every single member of KMA has been directly affected by the provider tax and reduced Medicaid reimbursement. Unfortunately, not very many members have chipped in to stop the hemorrhage of our Legal Trust Fund. Let me invoke a word of caution to the House of Delegates. Your leadership will do what we are directed to do by the House. However, we can't continue to adopt resolutions instructing KMA to take issues "all the way to the US Supreme Court," but neglect funding them. That is what is commonly known in the political circles as "unfunded mandates."

Despite all of our protestations and involvement with the Health System Reform, the Association continues to perform on all cylinders. While I have spent considerable time addressing HB 250, over 30 regular and ad hoc committees toiled throughout the year on many programs and very quietly served the profession and our patients. Far too often, we place emphasis upon our legislative, political, and legal battles and ignore those in the scientific, health, and safety trenches who continue to perform their duties with unselfish devotion. To those individual women and men I express profound gratitude.

The Board of Trustees will complete six meetings during this association year. It maintains liaison with allied groups; medical schools; governmental agencies; the Licensure Board; the media; the public; the Alliance; legislative activities from Frankfort to Washington, DC; and certainly, the Federation of Medicine — county societies, specialty groups, and the American Medical Association. The Board also maintains oversight on KMA committee matters including health delivery systems, care for the uninsured, school health affairs, socioeconomic issues, and dissemination of scientific and educational issues through such media as *The Journal of the Kentucky Medical Association* and this Annual Meeting.

Tremendous thanks is owed to the members of the KMA Board of Trustees for their ardent support through a very difficult period. Every Board member has experienced the very same frustration that you feel, and the same anguish over the way politicians and the media have distorted facts or outright lied to us. Board members wrestle with issues which they not only have to contend with as practitioners, but also struggle with corporately to resolve our mutual problems, either through the bureaucracy, legislature, or the courts. I have the greatest and utmost respect for each of them — who all too often have been criticized because they couldn't solve the problems. They are courageous and hard-working physicians who have given their time, talents, and leadership to the profession during a most disturbing and difficult journey. To each of them, I am eternally grateful.

## Legal Affairs

As previously mentioned, we had considerable legal activity this past year, and the following is a summary of that activity by Stites and Harbison on behalf of the Kentucky Medical Association during the period September 1994 to September 1995.

*KMA's Challenges to HB 250, September 1994:* Reviewed HB 250 and prepared memorandum for Executive Committee outlining possible legal challenges.

*KMA's Challenge to Medicaid Provider Tax, September/October 1994:* Completed research and prepared briefs on KMA's petition for a writ of certiorari to the United States Supreme Court seeking redress from adverse ruling by the Kentucky Supreme Court which upheld constitutionality of the Medicaid provider tax on physicians, thereby reversing decision by Franklin Circuit Court in favor of KMA.

*November 1995:* US Supreme Court denied KMA's petition for writ of certiorari.

*KMA's Challenge to Discount Option Program, September/October 1994:* Researched issues regarding legal challenge to the Kentucky Cabinet for Human Resources regulations to implement the Discount Option Program (DOP). Initially prepared to file a lawsuit; however, legal research was instead used by KMA officers and staff in a successful attack on implementation of the DOP program through administrative regulatory channels.

*KMA's Challenge to Medicaid Reimbursement Rate Cuts, September 1994:* Conducted legal research, contacted witnesses and parties, and gathered factual information to support legal challenge to emergency regulations

proposed by the Kentucky Cabinet for Human Resources to cut \$52 million from physician Medicaid reimbursement, effective October 15, 1994.

*October 1994:* Filed civil rights lawsuit in the United States District Court for the Eastern District of Kentucky, Frankfort Division, on behalf of KMA, certain named physicians and Medicaid patients against Masten Childers and the Kentucky Cabinet for Human Resources seeking to enjoin implementation of proposed rate cuts. Federal District Court granted KMA's motion for temporary restraining order on October 20, 1994, thereby stopping implementation of the rate cuts. Depositions of Masten Childers and other state Medicaid officials, together with the depositions of KMA representatives, were taken in late October in preparation for a hearing on preliminary injunction which was held on October 27 and 28, 1994.

*November 1994:* Federal District Court entered a preliminary injunction in KMA's favor on November 4, 1995, finding that the CHR had violated physicians' and patients' rights in failing to assess impact of Medicaid rate cuts on access to care throughout the state. The court prohibited implementation of rate cuts.

Briefs were submitted on CHR's request that Judge Hood stay implementation of the preliminary injunction. Judge Hood denied CHR's request. CHR then filed a motion with the United States Court of Appeals for the Sixth Circuit asking it to stay Judge Hood's injunction.

*December 1994:* The Sixth Circuit Court of Appeals granted CHR's motion for a stay pending appeal on December 13, 1994. This permitted the rate cut, originally scheduled for October 15, 1994, to go into effect on December 10, 1995.

KMA filed a motion asking the Sixth Circuit to reconsider its stay of the preliminary injunction.

*January 1995:* Judge Hood granted KMA's motion for a permanent injunction but, in light of the Sixth Circuit's ruling, stayed the effect of the permanent injunction pending appeal. CHR appealed the judgment in favor of KMA to the Sixth Circuit Court of Appeals.

*February/March 1995:* Prepared and filed briefs on appeal in the Sixth Circuit Court of Appeals.

*March/April 1995:* Settlement discussions with CHR coordinated by the Sixth Circuit Court of Appeals.

*June/July 1995:* Prepared and submitted a motion on behalf of KMA asking Judge Hood to lift the stay of his permanent injunction in light of the Kentucky Legislative Subcommittee's finding that CHR had violated legislative intent through its implementation of the Kentucky Medicaid rate cuts and in light of the CHR's failure to disclose Judge Hood's November 1994 findings when seeking HCFA's approval of amendments effecting the rate cut. Motion was denied on grounds that federal court in Frankfort no longer had jurisdiction.

*US Department of Justice Investigation of KMA and Northern Kentucky Physicians, May/July 1995:* Research and representation of KMA in responding to US Department of Justice's civil investigative demand for the production of various documents and other information pertaining to anti-trust investigation of Northern Kentucky physicians' withdrawal from the Medicaid program.

*KMA Pension Plan Amendments, June/July 1995:* Preparation and submission of amendments to KMA's pension plan necessary to comply with changes in federal law.

*Legal Update on Confidentiality Peer Records, June 1995:* Prepare memo on use by KMA staff regarding update on confidentiality of peer review records.

*Issues Pertaining to KMIC Stock, July 1995:* Research for advice to KMA Board of Trustees regarding KMIC stock issues.

*Issues Pertaining to Practice Parameters, July 1995:* Research and opinion letter regarding implementation of practice parameters.

## Summary of Board Meetings

### First Meeting, September 22, 1994

The KMA Board of Trustees held its reorganizational meeting for the 1994-95 Association year on September 22, 1994. Acting as temporary Chair, KMA Secretary-Treasurer William P. VonderHaar, MD, introduced the newly elected members of the Board and the new officers: Danny M. Clark, MD, Somerset, President-Elect; William H. Mitchell, MD, Richmond, Vice President; C. Kenneth Peters, MD, Jeffersonton, Speaker, House of Delegates; John W. McClellan, MD, Henderson, Vice Speaker, House of Delegates;





Donald R. Neel, MD, Owensboro, Trustee, 2nd District; and Kenneth R. Hauswald, MD, Ashland, Trustee, 13th District.

The Board elected the Executive Committee members to serve with the President, President-Elect, Vice President, and Secretary-Treasurer for the 1994-95 KMA year. Don R. Stephens, MD, Cynthiana, was reelected Chair, Board of Trustees, and Harry W. Carlross, MD, Paducah, was elected Vice Chair. Scott B. Scutchfield, MD, Danville, and Russell L. Travis, MD, Lexington, were named as Trustees-at-large.

It was noted that the KMA Executive Committee members also serve as the Board of Directors of KMA Physicians Services, Inc (KMA's holding company). The Board also made changes to the Kentucky Foundation for Medical Care Board of Directors in accordance with KPMC's Bylaws, and appointed KMA committees for the following year.

#### **Second Meeting, December 14-15, 1994**

The KMA Board of Trustees held its 1994 winter meeting at the Oxmoor Country Club on December 14 and 15. The Board members heard routine reports of the President; Secretary-Treasurer; Senior Delegate to AMA; Alliance President; Dean, University of Kentucky Medical Center; Chair, KEM-PAC Board of Directors; Chairman, KMIC Board of Directors; Commissioner for Health Services; and Board of Medical Licensure. In addition, special presentations were given by James B. Holloway, Jr, MD, Medical Director of the Medicare Part B Program in Kentucky, and Beverly M. Gaines, MD, the physician member of Kentucky's newly created Health Policy Board.

Committee chairs gave extensive reports, and highlights include:

**Membership Committee** — A steady increase in membership was reported with 1994 year-end total of 6,151 and 4,194 Active Members.

**Committee on State Legislative Activities** — Plans are underway to introduce an amendment to Section 54 of the Kentucky Constitution that would permit the General Assembly to limit the amount recoverable for noneconomic loss, punitive damages, and all other nonpecuniary damages arising from injuries resulting in death or injuries to person or property.

The committee was also authorized by the Board to look at onerous portions of HB 250, with the idea of introducing legislation to overturn such sections, with the Executive Committee to act as monitor.

**Committee on National Legislative Activities** — National health care reform efforts have been redirected to small-scale, incremental changes.

**Committee on Medical Insurance and Prepayment Plans** — The KMA Insurance Agency will continue to work with Blue Cross and Blue Shield to devise an enhanced group health care package for the membership, with renewal of the current contract extended until June 1, 1995.

In response to Resolution K (1993), the committee will continue to develop a closer liaison with major insurance carriers; in response to Resolution J (1993), the committee recommended as KMA policy, and the Board concurred, that an attending surgeon is the individual best qualified to determine whether or not an assistant surgeon is needed, and if so, the assisting physician should be compensated fairly. In implementing Resolution A (1994), the Board accepted the committee's recommendation that KMA identify those insurance companies that would allow a "pass through" of the tax imposed on physician gross revenues by 1994 House Bill 250.

**Committee on Public Education** — In reference to HB 250, the committee authorized the printing of bumper stickers stating "Repeal the Tax," as well as sample letters members and their patients can send to legislators regarding the tax.

In other committee activity, the Board Chair appointed the KMIC Board Election Nominating Committee, and a new Chair of the Committee on Continuing Medical Education.

Legal Counsel brought the Board members up to date on several legal matters in which KMA was involved. It was reported that the US Supreme Court had denied KMA's Petition for a Writ of Certiorari on HB 1, a previous provider tax bill, which let stand a Kentucky Supreme Court ruling that the tax was not unconstitutional.

A lengthy report was also given on KMA's lawsuit challenging the proposed decrease in Medicaid reimbursement, and the Board authorized funds from the Legal Trust Fund to continue the litigation. The Board also agreed that it was premature to legally challenge the Discount Option Program, but that a lawsuit could be considered at an appropriate time. It was noted that monies in KMA's Legal Trust Fund are being rapidly depleted, and options for funding will be considered before the next Board meeting.

In other action, the Board members appointed Jaroslav P. Stulc, MD,

Madisonville, to the Editorial Board of the *Journal of the Kentucky Medical Association*; submitted the name of James R. Smith, MD, Shelbyville, to the Board of Medical Licensure for appointment to its Physician Assistant Advisory Committee; and selected several physicians for service on a BCBS Workers' Compensation Advisory Committee.

#### **Third Meeting, April 12-13, 1995**

The KMA Board of Trustees met in regular session on April 12-13, 1995, at the Oxmoor Country Club in Louisville. The Board members heard reports from the President; Secretary-Treasurer; Alliance President; Dean, University of Louisville School of Medicine; President, Board of Medical Licensure; and the Vice Chair, KMIC Board of Directors. In addition, three of Kentucky's main gubernatorial candidates made presentations to the Board and provided written responses to questions relating to health care that had been sent to them before the meeting.

The Board members provided direction to legal counsel regarding future steps in the Medicaid reimbursement lawsuit KMA had previously filed, and agreed with the Executive Committee that legal action regarding HB 250 was not warranted at this time.

Extensive reports were given on different aspects of the Kentucky Health Policy Board including updates on practice parameters, Certificate of Need, standard benefit plans, and fraud and abuse regulations.

The Board members congratulated Past President Ardis Hoven, MD, on her appointment to the HCFA Practicing Physicians Advisory Council, and approved an expenditure of up to \$5,000 for a "Litigation Center" the AMA is establishing for the benefit of contingent medical associations. In other action, the Board approved four KMA group health plans presented by the KMA Insurance Agency, authorized expenses from the public relations budget for prelegislative conferences and cosponsorship of a seminar with the news media, and asked the Awards Committee to consider special recognition for physicians who participate in the Kentucky Physicians Care Program.

The Board also adopted a budget for the 1995-96 fiscal year, authorized reappointment of three Class B Directors on the KMIC Board of Directors, approved wording changes to the KMIC Articles of Incorporation, and selected nominees for service on Governor-appointed councils and boards.

#### **Fourth Meeting, August 9-10, 1995**

The Board of Trustees held its fourth meeting of the year on August 9-10, 1995, at the Holiday Inn Hurstbourne in Louisville. Reports were presented by the President, Secretary-Treasurer, Alliance President, and Senior Delegate to the AMA. In addition, presentations were made by the Dean, University of Kentucky School of Medicine; a member of the Licensure Board; Medical Director of Medicare Part B; Commissioner, Bureau for Health Services, and the President and Board Chair of the Kentucky Medical Insurance Company. A special report was presented by Beverly Gaines, MD, as a member of the Health Policy Board.

A detailed report on the Legal Trust Fund was presented and the Board voted a \$25 contribution be included on the 1995-96 dues billing statement. The current KMA policy on HB 250 was continued and nominations were forwarded to the Governor for service on the Board of Medical Licensure and the Drug Formulary Advisory Board. A number of committee actions were acted upon with recommendations from the Executive Committee and the *Journal* editors were appointed for the years 1995-97.

The Board went into executive session to hear reports on numerous legal activities from the KMA General Counsel. Next, the Board authorized a number of resolutions to be presented to the House of Delegates with subjects of 1) Women in Medicine Month, 2) Privatization of Medicaid, 3) Medicaid Block Grant Funding, 4) Medicaid Managed Care, and 5) Insurance Coverage for Obstetrical Care. Authorization was given for drafting additional resolutions.

Reports were then presented relating to the 1995 Annual Meeting in Lexington, computer training programs for physician offices, and workshops being planned on managed care and financial planning. A motion was also passed that KMA terminate its contract with the Ephraim McDowell Campus-Kenneth Farm, wherein KMA will no longer be responsible for the farm following the current owner's decease.

Noting that the House of Delegates last took action in 1991 to give the Board of Trustees authority in KMIC business combinations, etc; the Board voted to ask the House to again delegate authority to the Board of Trustees so the Board could act timely with respect to any proposals for the reorgani-



zation, reclassification, sale, merger, consolidation, share exchange, or other restructuring of KMIC. In 1991, the House of Delegates recognized the need for KMIC to have the flexibility to become a part of a larger group of companies, and a resolution is being introduced by the Board this year to reaffirm that concept and to provide appropriate Board authority.

The Board then reviewed all committee reports to be presented to the House of Delegates and gave recommendations on each. Some committee chairs were present to give oral reports. Actions taken to implement directives of the 1994 House of Delegates were distributed and will be made a part of the Board Chair's final report so each delegate will receive a copy.

The next meeting of the Board was scheduled for Sunday, September 17, 1995, during the Annual Meeting.

#### Executive Committee

The KMA Executive Committee has the responsibility of guiding the day-to-day operations of the Association and to research and give extensive consideration to major subjects presented to the Board of Trustees for action. The Executive Committee meets between sessions of the full Board and is composed of eight officers and Trustees. During this associational year, the Executive Committee met on six occasions with agenda issues concerning health system reform; legislative affairs; and legal issues, such as Medicaid reimbursement and the provider tax, being concerned agenda issues. Dedication to our members and the profession is partly expressed in the hours worked and many hours traveled by these physicians.

#### Quick Action Committee

The four Executive Committee members serving as the Quick Action Committee are the President, President-Elect, Chair of the Board, and Secretary-Treasurer. During state legislative sessions, the Chair of the State Legislative Activities Committee and immediate past president also serve to provide us with their counsel. The Quick Action Committee met formally five times and informally frequently this past year, so that policy could be established quickly for KMA when issues surfaced which needed quick disposition. This group will meet weekly during the 1996 Kentucky General Assembly and the total commitment of these physicians shines brightly in Frankfort, their second home for almost three and a half months. We all owe them our deep gratitude.

#### Ad Hoc Committee on KMA/KMIC Headquarters Location

The Ad Hoc Committee on KMA/KMIC Headquarters Location, chaired by Past President William B. Monnig, MD, reported that because of the changing status of KMIC, the Committee felt that there are no longer compelling reasons for KMA and KMIC to share a headquarters office. As a result, the KMA Board adopted a policy that KMA seek a lease arrangement for its headquarters office for the immediate years ahead, which may or may not be geographically associated with the KMIC headquarters. The Committee will continue to explore options for a headquarters site and will keep the Board informed of its progress.

#### Closing Thoughts

As I close this second year as Chair of your Board of Trustees, my thanks are extended to the House of Delegates, Board of Trustees, the committees, and individual members for the privilege you have given me to serve and for the support you have provided.

I have also had the opportunity to learn first-hand of the dedication, knowledge, experience, and ongoing effort of our staff. They each carry a heavy load on our behalf and I salute each staff member. With such effort by staff and with the membership accepting their proper role, our quest to reach new heights will be achieved.

**Donald R. Stephens, MD**  
Chair

#### Report of the Secretary-Treasurer

It is my pleasure to report to you as Secretary-Treasurer and to bring you greetings on behalf of the Association. All are aware of the significant dynamics that continue to confront the profession, but I am pleased to report that, administratively, your Association continues to function well and with routine steadiness.

This year the Board was pleased to welcome new members Donald R. Neel, MD, Owensboro, representing the Second District, and Kenneth R.

Hauswald, MD, of Ashland, representing the Thirteenth District. In addition, Donald J. Swikert, MD, of Florence, began service as an AMA Delegate, and Irene Minor, MD, Berea, and William B. Monnig, MD, Edgewood, joined the Board as Alternate AMA Delegates.

The economic state of the Association is sound, and I invite the attention of the Delegates and the entire membership to the budget report that will be issued at the meeting. Any questions are welcomed regarding the budget and its expenditures.

On a related budget item, this House of Delegates voted last year to increase the contribution to the Legal Trust Fund to \$25. In addition, a special voluntary assessment for the Trust Fund was made this year to satisfy legal cost demands directed by the House relating to the Medicaid Provider Tax. These funds were depleted to resolve that question, although the voluntary contributions were not universally made. It is important to note the responsibility of the officers, the Board, and members of the House of Delegates, as the leadership of the Association, to support actions voted. In this instance, all members of the House have an obligation to vocally support this vote among their local constituents.

Membership has maintained steady growth that is encouraging. The membership totals for this year are ahead of the numbers for the same time last year and, once again, focus has been on new physicians, whose participation is vital, not only for our Association, but for our profession. House members are urged to take a leadership role here, too, among their local constituencies.

Next year we can anticipate the bulk of the Association's activities again being directed toward legislation at both the state and national levels. Other reports contained in this booklet will detail anticipated issues on the state level, which will include work to repeal the Provider Tax, efforts to amend HB 250 from the previous state legislative session, and issues surrounding nonphysician medical personnel. At the national level, budget issues related to Medicare and Medicaid will undoubtedly occupy the bulk of KMA's attention, as will managed care issues, antitrust concerns, and patient freedom of choice.

As Secretary, I would urge any member or Delegate to express any questions or concerns you may have, and appreciate the opportunity to serve you.

**William P. VonderHaar, MD**  
Secretary-Treasurer

#### Report of the Editor

*The Journal of the Kentucky Medical Association* serves as an educational exchange, a permanent record of the Association, and a newsletter for Kentucky physicians. We're the only publication in an ideal position to focus on the entire medical community, regardless of specialties or hospital affiliations. *The Journal* belongs to each member and its success lies in the hands of the membership.

*The Journal* is committed to publishing educational material that is of high quality and relevance. We encourage the submission of original research, case studies, medical history, and diagnostic and therapeutic updates, as well as commentaries and letters to the editor on all subjects of interest to Kentucky physicians. The topics we publish typically apply to specialties across the board, and while we do not attempt to compete with specialty journals, we do publish specialized articles that tend to be unusual or interesting case reports by Kentucky physicians.

During 1994, *The Journal* featured 28 original scientific articles representing the efforts of 89 authors and 4 Grand Rounds contributions from the University of Kentucky and University of Louisville medical schools representing 8 authors. Also featured during the year were socioeconomic and legislative updates; Association activities; member news; a special report from the Committee to Investigate Changing Trends in Medicine; several thoughtful and knowledgeable contributions by Book Review Author Stephen Z. Smith, MD; Alliance updates; and Kentucky Physicians Care pharmaceutical revisions.

Following tradition, the July issue highlighted the location of the Annual Meeting; the August issue contained the entire preliminary program for the Annual Meeting; the October issue profiled our 1994-95 President, Robert R. Goodin, MD; and the December issue reported the entire proceedings of the House of Delegates and the activities of the Annual Meeting.





The members of the Editorial Board have continued their record of excellent service, and I will take this occasion to thank each of them for giving generously of their time for the success of *The Journal*: Drs Daniel W. Varga, Scientific Editor; Stephen Z. Smith, Assistant Scientific Editor; Jannice O. Aaron, Martha Keeney Heyburn, Milton F. Miller, and Jaroslav P. Stulc, Assistant Editors. Dr "Jerry" Stulc, a surgeon with the Trover Clinic in Madisonville, joined the Board in December 1994 and is the newest member of our team. He has stepped into his editor's role with obvious dedication, resourcefulness, and incisiveness.

There were eight Editorial Board meetings during 1994, and of the 37 manuscripts reviewed, the Board rejected 6 and returned 4 with recommendations for revision, indicating a 73% acceptance rate.

Financially, 1994 was not as successful as previous years, but scientific publishing has been seeing a downturn for several years in available advertising money nationwide, and we had to struggle for our share. Local advertising is holding its own and efforts are being made to increase that revenue.

The Editorial Board of *The Journal* encourages KMA members to communicate regularly and often about any and all facets of the publication. Your feedback will serve as positive reinforcement or constructive criticism. We welcome your comments.

The Editorial Board thanks the Board of Trustees for its continuing support and interest in *The Journal*.

**A. Evan Overstreet, MD**  
Editor

## Report of the Delegates to AMA

Greetings, from your AMA Delegation. I am pleased to report to you on behalf of the Delegation to the American Medical Association, your elected representatives to our national organization.

Since the last meeting of this House of Delegates, the AMA Delegation has met twice, and the Association has been well represented. In addition to the five Delegates and Alternate Delegates you have elected, the Delegation is routinely joined by representatives from the Jefferson and Fayette county medical societies, the Young Physicians Section, the Resident Physicians Section, the Medical Student Section, and the Hospital Medical Staff Section.

Kentucky's efforts at the national level are further enhanced by the selection of some individuals from our state to various positions in the AMA. William B. Monnig, MD, Edgewood, serves as an at-large member of the Organized Medical Staff Section (Hospital Medical Staff Section); Judy Linger, MD, Georgetown, serves as the Chair of the Resident Physicians Section; Bruce Scott, MD, Louisville, was just elected as an at-large board member of the Young Physicians Section; Bob Goodin, MD, of Louisville, is a member of the Continuing Medical Education Advisory Committee; Ardis Hoven, MD, Lexington, serves on the Group Practice Advisory Committee; and Baretta Casey, MD, Pikeville, was just awarded the annual Community Service Award by the AMA Young Physicians Section for her work in KMA's campaign against domestic violence. While these individuals have been selected based on their own merit and competence, they also reflect well on KMA.

This year the Delegation was pleased to welcome Don Swikert, MD, Florence, as a Delegate. Don was elected by this House last year after having served as an Alternate Delegate. New Alternate Delegates of our group are William B. Monnig, MD, Edgewood, and Irene G. Minor, MD, Berea.

A highlight of our activities this year was the nomination of Bob Goodin by the KMA Board of Trustees to run for a position on the AMA Council on Medical Education. This nomination was approved by the AMA Board of Trustees, and the campaign and election took place at the June AMA meeting. For this race, seven candidates ran for four open positions, and these candidates included three incumbents. Bob was a very effective and articulate candidate, and although not successful, ran a close and notable race. Your AMA Delegation was extremely proud of the race and the showing that he made.

Since that race, we have learned of the unfortunate demise of one of the incumbent members of that Council, and the AMA has announced a vacancy and an open race for that position at the meeting in December. The AMA Delegation has urged Dr Goodin to run again, and the KMA Board has again supported his nomination. It is the Delegation's plan to, again,

conduct an energetic and optimistic campaign and we are most appreciative of the support of the Board of Trustees, as well as the entire Association.

At each meeting, the Delegates consider the reports of over 80 councils and commissions and in excess of 200 resolutions. Each item of business is considered, discussed, and voted on, and a review of highlights of some of these issues is appropriate.

In December, the House approved the creation of a specific position for a young physician on the AMA Board of Trustees, opposed the payment of a finder's fee for referral of patients for research studies, and considered the ethical use of organ donation from anencephalic donors and the encouragement of patients to submit letters to legislators on behalf of medical concerns.

The House also voted to seek an incremental approach to future health system reform efforts and to encourage the AMA to help states in health reform efforts.

With regard to gatekeepers, the House developed a policy that patient access to services should not be limited by the specialty of the physician, but by the training, competence, and experience of the physician to provide primary services. The AMA was directed to work for the repeal of insurance antitrust exemptions, limiting third-party payors' random access to patient medical records, and support for legislative initiatives to pay for physician training costs in nontraditional sites.

At this meeting, the House also voted to support drug and alcohol screening for adolescent accident and injury victims, the use of ZDV to reduce perinatal transmission of HIV by pregnant women, efforts to increase the number of minorities registered as potential bone marrow donors, the encouragement of physicians to educate patients about the relationship between antibiotic use and antibiotic-resistant bacteria, opposition to various health plan restrictions, and the development of an AMA resource-based relative value scale.

One of the major issues of discussion at the June meeting related to Medicare. There is little question that Medicare program expenditures will be reduced over the next five to seven years in the interest of balancing the budget. The overwhelming question is how this reduction will be imposed. To this end, the AMA has developed a proposal for restructuring the Medicare program, which calls for more cost responsibility on the part of beneficiaries, a restructuring of contribution levels by consumers to the program based on age, the removal of antitrust barriers, and encouragement of competition among providers. Medicaid was also much discussed, and the House expressed concern about operating Medicaid through block grants without close monitoring of the methods by which states use these grants.

The House voted strong continuing support for professional liability reform and opposition of preemption by federal law of state-imposed liability caps. The House took a strong position regarding the role of physician assistant and nurse practitioner relationships, and declared that these practitioners should be supervised by physicians.

Many other and detailed matters were discussed and, of course, these are ongoing considerations.

On behalf of the AMA Delegation, we humbly appreciate your support and urge any questions or comments you may have.

**Donald C. Barton, MD**  
Senior Delegate

## Report of the Executive Vice President

"What a year!" — During my 33 years of service to Kentucky physicians, KMA has only gone to the courts one time to resolve a major legal problem. In 1976 we were able to garner the Governor and General Assembly's support for an extensive professional liability reform package and the legislation was subsequently adopted. In turn, we "sued ourselves" to determine the constitutionality of the legislation. All that peace and harmony changed with the passage of House Bill 250 and the provider tax. We carried the fight against the provider tax all the way through the state courts to the Kentucky Supreme Court. We then appealed to the federal system but the US Supreme Court eventually denied and refused to hear our arguments. In the meantime, the administration announced "unconscionable" Medicaid reimbursement reductions and KMA decided to challenge the state's authority in the federal courts. We prevailed in the lower federal courts under



Judge Joseph Hood and await CHR's appeal in the Federal Appellate Court in Cincinnati. These two court challenges depleted our Legal Trust Fund and the Board of Trustees voted a voluntary assessment of \$100.00 per member to continue pursuit of our case in the federal courts. Approximately 25% of members have responded to the request at printing time.

Officers and staff have devoted considerable time and effort to the implementation of HB 250. Following passage of the legislation, KMA staff and legal counsel completed an extensive analysis of the bill to identify sections with potential for legal challenge either from a state or federal constitutional perspective. The legal synopsis of HB 250 was reviewed by the KMA Quick Action Committee, Executive Committee, and then forwarded to the Board of Trustees. The Board voted overwhelmingly to postpone contesting HB 250 and concentrate its limited resources on the provider tax and the Medicaid reimbursement cuts. However, several sections of HB 250 are monitored daily, which if implemented improperly may be challenged. We tracked the "fee posting" provisions, vigorously protested attempts to go beyond legislative intent and were able to bring about modifications. At every Quick Action Committee, Executive Committee, and KMA Board meeting, we carefully reviewed HB 250 including the Discount Option Program, development of practice parameters, data gathering, etc, which may have legal flaws.

In an effort to coordinate activities and open communication with the Health Policy Board (HPB), the Kentucky Hospital Association and Kentucky Medical Association, represented by officers and staff, formed a Joint Oversight Group (JOG). The purpose of JOG is to meet with individual members and executive staff of the HPB and establish direct lines of communication. We have met with practically all of the Health Policy Board members and shared concerns with HB 250 and articulated our positions on various sections of HB 250 being implemented by the HPB. Beverly M. Gaines, MD, physician representative on the Health Policy Board, has worked primarily with components of HB 250 dealing directly with medical practice. Dr Gaines met periodically with KMA officers, staff, Board of Trustees, and the presidents and representatives of various specialty groups, designing and refining the "fee posting" provisions of HB 250. In addition, she has worked steadily in the practice parameter arena and invited KMA to nominate physicians for the various working committees ultimately charged with developing parameters. This is an issue in which we intend to provide tremendous input, and from the KMA Board's perspective, practice parameters represent one of our key concerns as HB 250 is implemented.

The Cabinet for Human Resources senior management has been strident in their "public" relationships with KMA and physicians. On the other hand, they have been far more conciliatory in "private" meetings with KMA. The Secretary of CHR has met with our leadership on three occasions, primarily seeking support for privatization of Medicaid. Unfortunately, for patients and the profession, dialogue has generally been a one-way street with "them talking and us listening." The litigious climate, emerging as a result of our challenge to the provider tax and Medicaid reimbursement cuts, has created a glass barrier between CHR and KMA. While we have been able to communicate on the Discount Option Program and fraud and abuse regulations, the relationship has been tentative at best. We are hopeful that the new administration will be more open and fair. Above all, we are weary of the vindictiveness and open warfare generated by the present administration. We look forward with great anticipation to December 1995.

In order to open communication with the succeeding Governor and administration, and to provide physicians a candidate's perspective on medical/health issues, the Board of Trustees conducted a gubernatorial forum in April. The May issue of the *Journal* printed each candidate's response to our questions. Both winning candidates responded to our questionnaire and are expected to appear at the annual KEMPAC seminar in September.

Due to the fact that all members of the "KMA family" report to the House of Delegates, this report will not dwell upon them to any great extent. The KMA Alliance, Kentucky Medical Insurance Company, Rural Kentucky Medical Scholarship Fund, and KEMPAC have had an exciting and strong 1994-95 year. These extended organizations created by KMA to serve patients, the profession, and their families, have tremendously augmented KMA's efforts. We owe a great deal of thanks to these five organizations including their boards and staff for the work they do.

In 1995, we welcomed a new "extended family member" in the Impaired Physicians Program (IPC). The IPC is no longer a KMA entity but a

committee of the newly formed Kentucky Physicians Health Foundation's Board of Directors. The foundation contracts with the Board of Licensure to provide IPC services with funds generated from licensure registration fees. The Impaired Physicians Committee has hired staff and is housed separately from KMA. We are extremely proud of IPC's effort and wish them well as they continue their work.

KMA membership continues to grow and a recent AMA study affirmed our belief that Kentucky physicians are extremely supportive and loyal to their state medical association. We were proud to learn that based on a recent AMA study, KMA ranks 7th nationally in terms of membership "market share" when compared with other state associations. According to the AMA study, KMA members comprise 71.5% of the state's physician population while the national average is only 53.1%. Even though we have four months remaining, membership is running ahead of last year's record. The true test of whether an association is doing the job and responding to its constituents is always reflected by its growth. We believe continued growth is an endorsement of KMA leadership and a reaffirmation from the vast majority of Kentucky physicians who feel well served by the policies and activities of their Kentucky Medical Association. We do, indeed, exist to serve you, the member.

Financially, the Association remains strong and that strength can be attributed to the dedication of our Budget Committee under the guidance and leadership of Richard Hench, MD, and the oversight of the Executive Committee and Board of Trustees. We continue to be impressed with the fiscal expertise of the Budget Committee and we all remain dedicated to our role as conservators of member dues. Despite the fact that membership has almost doubled in the past fifteen years, we have 10% less staff today than in 1980. Staff continues to search for ways to increase service and reduce costs. Leadership is very responsive to our needs and supports efforts to update equipment to increase member services. We are cognizant of the fact that as the health dollar declines, physician income is also reduced. In 1995-96, we enter the 9th year of an originally designated 5-year dues plan. We fully expect to extend that 5-year projection to the 10th year and beyond without a dues increase.

The first three words of this report clearly express how this year has affected KMA. "What a year," also reflects how our officers have given of themselves and their time. President Bob Goodin, MD, has not been a "traffic cop" type of leader. By his sacrifices and examples, he has motivated us to do more — and do better. His preparation, knowledge, experience, and above all his willingness to pitch in and get the job done under trying circumstances have made a difficult year not only interesting, but successful. He has articulated the concerns of physicians as well as anyone in memory. He has never forgotten his rural roots, which has been a bonus Kentucky physicians received when they elected him to the Association's highest office. Dr Bob and Carol Goodin have made us all proud. When you see him — thank him — Kentucky medicine is better today because of him.

No let up in pressure is in sight for medicine and if ever the Association needed experience, 1995-96 is the year. Dr Danny Clark, our President-Elect, has served on the Board for many years and his experience as Trustee, Vice Speaker, and Speaker of the House will serve him well. We enter the 1996 legislative session with a great deal of optimism along with a healthy dose of trepidation. If membership works as hard as leadership, I am confident we can survive another legislative onslaught and hopefully obtain relief from the provider tax and oppressive sections of HB 250.

It is difficult to write a report or give a presentation to physicians without bringing up the shopworn word UNITY. Unfortunately, there are no words that adequately describe medicine at this juncture. We enter an era some call the "crossroads of medicine." Events are occurring at breakneck speed that may be irreversible. I am deeply concerned with the dramatic and unchecked growth of managed care, the purchase of physicians' practices, and the loss of physician and patient freedoms. In a brief period of time, medicine can become the same cutthroat business as other enterprises. The corporate bottom line, rather than the patient, is rapidly becoming the driving force of health care. Recently, a report crossed my desk entitled "The States That Could Not Wait" which detailed lessons for health reform. Under essential steps to success, one recommendation stood out:

*Remember that opposition groups are not monolithic. Exploit the splinter groups among the providers and within the insurance industry.*

Every physician should remember that statement. The survival of medi-





cine is tied irrevocably to the federation of medicine — and by that I mean specialty group, county society, state association, and the AMA. Nothing has been more damaging to the body of medicine than physicians and other groups appearing before Congress and exploiting the fact that AMA represents less than 50% of American medicine. We witnessed similar episodes in Frankfort by folks championing their own causes at the expense of patients and the profession. The federation is a classic example of democracy. No governing structure or system is more representative or more capable of serving physicians. Through unity, we multiply our efforts and lighten our load.

As managed care expands, our adversaries may become our friends, and our friends our adversaries. In 1994 the most vehement attack upon physicians came not from public advocacy or labor groups but from business, industry, and insurance companies. Based on events in Washington, other states' difficulties, and our own recent experience, we may see a realignment of allies and adversaries. It is crucial that every physician becomes involved in their local and state chamber of commerce. In 1994, the Kentucky Chamber of Commerce shocked me by endorsing House Bill 250 and the provider tax. Despite an unprecedented attack on 1/7th of this state's economy (the health care industry), our business representation took a hike. This situation is unacceptable and should become a major focus of medicine in the coming months as we plan for the 1996 session and beyond. In Kentucky, the Workers' Compensation program and the rising health cost component of that program places employers at odds with providers. When the cost of employer/employee health insurance is folded into that equation, a potential for warfare between the groups becomes imminent unless some form of intervention is undertaken. We need your involvement.

Special thanks to our 40-plus committees that labored all year long representing and wrestling with medical practice issues. The 1994-95 KMA Board of Trustees under the able leadership of Chair Don Stephens, MD, has dealt with enormous issues that few boards have faced. To their credit, they faced the issues head-on and never wavered in their resolve.

We work very closely with William P. VonderHaar, MD, KMA Secretary-Treasurer. Dr VonderHaar gives KMA hundreds of hours every year working with our staff members on a day-to-day basis and representing us with other organizations. We are appreciative of his service.

I close by thanking staff members who work everyday on behalf of physicians. They are truly dedicated and committed to the profession and to your patients. Through retirement, transfers, and for health reasons, we have lost a few experienced dedicated employees this year. I must mention my Administrative Assistant, Debby Traugher, who has been at my side for 22 years. She's made sure all of our assignments were completed on time and done properly. She plans to do a little part-time work to help us out, but the Association and I, personally, will miss her deeply. We have been extremely fortunate in adding new staff members to replace those departing. Their work ethic and positive attitudes have made them like old pros in a short time.

We thank the members for the opportunities and responsibilities that have been entrusted to us. We look forward to an effective and productive year.

**Robert G. Cox**  
Executive Vice President

## Report of KMA Physicians Services, Inc

KMA Physicians Services, Inc, is the only wholly owned subsidiary of the Kentucky Medical Association, and serves as a holding company to its own subsidiary, the KMA Building Corporation.

The KMA Building Corporation was formed when we owned our own headquarters building, which was sold in 1991 to Hospice of Louisville, Inc. The Building Corporation received the proceeds from the sale of the old headquarters building and transferred them to KMA's building fund for future use. The KMA is currently leasing space with a lease agreement lasting through 1996. A committee continues to study criteria for a future home for KMA.

**Don R. Stephens, MD**  
Chair

## Report of the Kentucky Medical Insurance Company Highlights

Kentucky Medical Insurance Company has had a challenging year. But it has not been without rewards. The company remains strong and stable. By midyear, KMIC showed an improvement in financial results. Furthermore, KMIC's A M Best rating of A- (Excellent) was reconfirmed and the number of policyholders is growing, reaching the highest level since 1988.

Other highlights of 1995 (through August 28th) include:

- Successfully resolved a proxy contest with dissident shareholders.
- Aggressively marketing to physicians in Ohio. The company has quoted approximately \$20 million in new premiums in the state and won approximately \$1 million in new business.
- Claims frequency is up. Through July, 186 new claims were opened. This compares with 134 new claims opened for the same period of 1994. However, indemnity payments are down from 1994 figures. Essentially, the company is successfully closing claims for less money.
- Kentucky Medical continues to be aggressive in taking claims to court. Through August 28th, 25 claims have been tried. The company won 20 of those claims that went to trial.
- Second quarter net income was 71% higher than the second quarter of 1994.
- KMIC's largest subsidiary, United Leasing, has a solid track record of strong performance. The leasing company once again surpassed previous records for sales and profitability.
- The KMA Insurance Agency, another KMIC subsidiary, continues its transition into new product areas and growth. A joint venture with InsuraMax is expected to boost the insurance agency's growth.

## Opportunities

- Collaboration with other insurance companies remains a high priority for KMIC. Through collaboration, the company can more quickly reach its goals for product and geographic expansion. As health care providers consolidate and grow, KMIC is preparing to serve the future market. The benefits of collaboration include reducing operating expenses and a broader offering of products and services.
- KMIC will continue to seek market growth in the neighboring states of Ohio, Indiana, and Tennessee.
- An analysis is currently underway to evaluate the value of adding worker's compensation insurance to the KMA Insurance Agency product line.
- Kentucky Medical is encouraged by its success in reducing the cost of settling and trying claims. Innovative measures will continue to lower claims-related expenses.

## Concerns

- Claims frequency is up.
- Competition remains stiff in all states in which the company is licensed.
- Low interest rates continue to adversely affect KMIC's investment income.
- Depressed stock prices and declining profits continue to proliferate the P&C insurance industry.

## Conclusion

Kentucky Medical Insurance Company remains financially strong and stable. While pleased with the company's steady growth, rapid expansion through collaboration remains a key strategy.

**Richard F. Hench, MD**  
Chair

## Report of the Ephraim McDowell Cambus-Kenneth Foundation, Inc

The Ephraim McDowell Cambus-Kenneth Foundation, was incorporated on May 26, 1988, as a not-for-profit Kentucky corporation and exists exclusively for "charitable and education purposes in promoting an appreciation of history through the acquisition, restoration, and preservation of buildings and properties having special historic significance."

The Foundation was formed by the Kentucky Medical Association for the purpose of accepting from Mr Joe A. Wallace and Mrs Cecil Dulin Wallace, upon their deaths, the 550-acre Cambus-Kenneth Farm located in Danville. As many of you know, Mr Wallace passed away in late 1992.



Today, the Farm remains with Mrs Wallace, recipient of the 1993 KMA Award. The Cambus-Kenneth Farm was owned at one time by the pioneer physician, Ephraim McDowell, MD; served as his summer home; and was the site of his death. Additionally, the assets of the former McDowell Memorial Fund, including the McDowell House and Apothecary Shop, also located in Danville, were conveyed to the Foundation by the Kentucky Medical Association.

The Foundation's Board of Directors met on September 22, 1994, and elected the following corporate officers for 1994-95: Robert R. Goodin, MD, President; and William P. VonderHaar, MD, to a combined office of Vice-President and Secretary-Treasurer. Other members of the Foundation Board include John W. McClellan, MD; Scott B. Scutchfield, MD; G. Russell Shearer, MD; and David W. Kinnaird, MD, as an ex-officio member.

The McDowell House Managers Committee operates under the auspices of the Foundation to supervise the maintenance and operation of the McDowell House and Apothecary Shop. A report on the financial status of the McDowell House will be presented to the Foundation's Board of Directors at its annual meeting in September. However, finances seem to be in good order. The Managers Committee is placing additional emphasis on the "Friends of the McDowell House" project in an attempt to increase the number of Friends and to increase financial gifts to the McDowell House.

The Kentucky Medical Association Alliance has continued to play an important role in maintaining and adding to the collection of the McDowell House and has been very faithful in its participation.

The Foundation's Board of Directors continues to meet regularly with Mrs Wallace and others to explore its options and opportunities should the Farm be conveyed to the Foundation. More news on this matter should be forthcoming in the near future.

The Foundation Board would like to thank Russell Shearer, MD, Chair of the McDowell House Managers Committee, as well as the Committee members, McDowell House staff, and volunteers who have made the operation of the Foundation a success during the last year. I would also like to express my personal appreciation to the other members of the Foundation Board for their service during this past year.

**Robert R. Goodin, MD**  
**President**

## END OF CONSENT CALENDAR ITEMS

### Report of the Physician Advisory Committee to Health Kentucky (Health Care Access Foundation)

The KMA House of Delegates voted to approve Kentucky Physicians Care in September 1984 with an implementation date of January 1, 1985. January 1995 marked the completion of the tenth year of this most significant and unique service to Kentucky, and certainly participating physicians can be extremely proud of care given so freely over this period of time.

When the House approved Kentucky Physicians Care, it did so for one year with any extensions to be approved by the House of Delegates. The House has voted to extend the program nine times.

Since the program began operation in January, 1985, 135,608 calls have been made to the 800 number by clients asking for referrals or for information on applying for the program. Currently, 2,289 physicians participate in the program and a total of 55,015 referrals have been made throughout the program's existence. As the House is aware, once patients are in the system, they usually do not call back for follow-up visit authorizations. The physician usually sees them in follow-up as a normal course. Similarly, referrals to nonprimary care physicians take place without going through the 800 number. The services of hospital-based specialists are not reflected in the referral numbers either, since most of these services are coordinated through the attending physician once the patient is hospitalized. Thus, it is reasonable to assume that the number of patient/physician encounters, as a result of KPC, is far greater than the 55,015 logged referrals. The committee believes an estimated ratio of four encounters per referral may be low, but even so, that would equate to over 220,000 free encounters for the 136,142 individuals who were certified for the program over its ten-year existence.

In addition to KMA's participation and that of the 100 participating Kentucky hospitals, 321 participating dentists have had 3,735 referrals since

1991. A total of 36,377 free prescriptions have been filled by 431 participating pharmacists since 1990. An unknown number of free home health care and hospice services have been provided as well. Clearly, the project has been a meaningful undertaking and all involved can be proud of their roles.

Last year, the committee recommended that overall program responsibility for Kentucky Physicians Care be transferred from KMA to Health Kentucky, the foundation which oversees the coordination of the entire access program. It appears to the committee that the change has been a positive one. KMA has three members of the KMA Board serving on the Board of Health Kentucky. They are Ardis Hoven, MD; Salem George, MD; and Donald Barton, MD.

The committee met on one occasion this year with staff from the foundation, and was advised that several counties had a low number of participating physicians. The committee made an effort to encourage physicians in those counties to participate and completed a routine recruitment of newly licensed physicians.

As in the past, the committee continues to feel that the program is very worthwhile and serves the useful purpose of providing a conduit for individuals to primary physician services. For that reason, the committee recommends:

1. KMA continue its endorsement of the Health Kentucky goal of increasing access to care for Kentucky's less fortunate citizens.
2. KMA encourage all Kentucky physicians to continue to voluntarily participate in Kentucky Physicians Care to the extent possible.
3. KMA continue its endorsement of Health Kentucky contingent on:
  - a. program funding being continued, as appropriate, by Health Kentucky.
  - b. a continuing commitment from the Cabinet for Human Resources to evaluate the program applicants for eligibility as is currently done.
  - c. the other participating provider groups maintaining the same or increased level of participation in the foundation program.
  - d. Health Kentucky making documented efforts to vigorously encourage the participation of all other health care delivery and/or financing organizations in the foundation's program, as may be appropriate.
  - e. Health Kentucky making documented efforts to make Kentucky legislators and the general public aware of the plight of those ineligible for Medicaid assistance, solely because they do not meet the confusing and arbitrary requirements of the Medicaid program, while working to broaden the societal financial obligation necessary to provide care to those in need of such assistance.

As Chair of the Advisory Committee, I very much appreciate the continued interest and participation of the members of the Advisory Committee. I am humbled by the generosity of the physicians in this state who continue to give so freely and generously of their services.

**Russell L. Travis, MD**  
**Chair**

## RECOMMENDATIONS:

1. KMA continue its endorsement of the Health Kentucky goal of increasing access to care for Kentucky's less fortunate citizens.
2. KMA encourage all Kentucky physicians to continue to voluntarily participate in Kentucky Physicians Care to the extent possible.
3. KMA continue its endorsement of Health Kentucky contingent on:
  - a. program funding being continued, as appropriate, by Health Kentucky.
  - b. a continuing commitment from the Cabinet for Human Resources to evaluate the program applicants for eligibility as is currently done.
  - c. the other participating provider groups maintaining the same or increased level of participation in the foundation program.
  - d. Health Kentucky making documented efforts to vigorously encourage the participation of all other health care delivery and/or financing organizations in the foundation's program, as may be appropriate.
  - e. Health Kentucky making documented efforts to make Kentucky legislators and the general public aware of the plight of those ineligible for Medicaid assistance, solely because they do not meet the confusing and arbitrary requirements of the Medicaid program,





while working to broaden the societal financial obligation necessary to provide care to those in need of such assistance.

#### **Recommendations, Reference Committee 1:**

Reference Committee No. 1 reviewed the Report of the Physician Advisory Committee to Health Kentucky and recommends that the report and its Recommendations be adopted.

## **RESOLUTION G**

### **Board Authority for Any KMIC Restructuring KMA Board of Trustees**

WHEREAS, the Kentucky Medical Association (the "KMA") owns all of the outstanding shares of Class B common stock of Kentucky Medical Insurance Company ("KMIC"); and

WHEREAS, the KMA House of Delegates wishes to delegate authority to the Board of Trustees to consider and act on behalf of the KMA with respect to any proposals submitted by KMIC to its shareholders for the reorganization, reclassification, sale, merger, consolidation, share exchange, or other restructuring of KMIC; now, therefore, be it

RESOLVED, that the KMA House of Delegates hereby authorizes and directs the Board of Trustees to act on behalf of the KMA in connection with any and all proposals submitted generally to all KMIC shareholders, or solely to KMA as the holder of all the outstanding Class B common stock, for the restructuring or reorganization of KMIC, including without limitation, any proposals to (i) amend the articles of incorporation of KMIC to reclassify or amend its existing capital stock structure and the various rights, limitations, and preferences given to each class of capital stock, (ii) establish a holding company structure to permit KMIC to become a part of a larger group of companies, or (iii) sell, merge, consolidate, or exchange the outstanding shares of KMIC, on such terms and conditions and for such consideration as the Board of Trustees shall determine to be reasonable and fair and in the best interests of the KMA; and be it further

RESOLVED, in connection with its evaluation of any of the foregoing matters, the Board of Trustees shall consider, among other things, the extent to which KMIC would continue functions such as claims handling, underwriting, and marketing on a local basis in Kentucky, whether KMA would continue to nominate candidates for board membership, and the extent to which insurance rates for KMIC-insured physicians would continue to be fixed based upon local experience; and be it further

RESOLVED, in connection with its evaluation of any proposal for the merger or consolidation of KMIC or for the sale or exchange of the Class B common stock owned by the KMA, the Board of Trustees shall be empowered to engage the services of legal and financial advisors, and shall be entitled to rely in good faith upon the advice and recommendations of such advisors; and be it further

RESOLVED, in connection with the foregoing matter, the Board of Trustees shall have all the power of the House of Delegates and the decision of the Board of Trustees shall be final, conclusive, and binding on the Kentucky Medical Association without further action by the House of Delegates.

#### **Recommendations, Reference Committee 1:**

The Reference Committee reviewed Resolution G, Board Authority for Any KMIC Restructuring, introduced by the Board of Trustees.

The Reference Committee heard extensive testimony from representatives of the Board of Trustees, the Kentucky Medical Insurance Company and concerned members.

Reference Committee No. 1 recommends Resolution G be adopted.

## **RESOLUTION P**

### **Release of Patient Information to the Health Policy Board Warren County Medical Society**

WHEREAS, patient/physician confidentiality is one of the most sacred tenants of medical care of the United States; and

WHEREAS, this confidentiality is protected by law; and

WHEREAS, release of such information may be illegal; and

WHEREAS, gathering of this information is time-consuming and expensive to health care providers; now, therefore be it

RESOLVED, that the Kentucky Medical Association use all appropriate legal, judicial, legislative, or administrative actions at its disposal to stop the Health Policy Board's ability to pry into the private health care matters of the citizens of the Commonwealth of Kentucky.

#### **Recommendations, Reference Committee 1:**

The Reference Committee considered Resolution P, Release of Patient Information to the Health Policy Board, introduced by the Warren County Medical Society.

After hearing testimony the Reference Committee was in accordance with the intent of the author to protect the confidential nature of patient records as well as the time-consuming and inconvenient aspects of data collection now required by the Health Policy Board. However, because the confidentiality of the data being required is not in jeopardy and data collection is a mandated task of the Health Policy Board by statute, the Reference Committee recommends that Resolution P be rejected.

The Board of Trustees offered a substitute for Resolution P, as follows:

RESOLVED, that the Kentucky Medical Association continue to monitor and take action as indicated to assure that information collected by the Health Policy Board protects the confidentiality of the physician-patient relationship; and be it further

RESOLVED, that KMA pursue, via reasonable legislative, administrative and legal means, all onerous portions of House Bill 250, including those portions pertaining to reporting of data to the Health Policy Board by physicians; and be it further

RESOLVED, that KMA continue its unrelenting efforts to focus its legislative efforts to effect health care reform that promotes high quality patient care through effective use of physician resources.

A motion was made from the floor to substitute the word "oppose" for the word "pursue" in the second Resolved. The motion was seconded and carried.

A subsequent motion was made, seconded, and carried to adopt Substitute Resolution P, as amended.

**Substitute Resolution P, adopted as amended by the House, reads as follows:**

RESOLVED, that the Kentucky Medical Association continue to monitor and take action as indicated to assure that information collected by the Health Policy Board protects the confidentiality of the physician-patient relationship; and be it further

RESOLVED, that KMA oppose, via reasonable legislative, administrative and legal means, all onerous portions of House Bill 250, including those portions pertaining to reporting of data to the Health Policy Board by physicians; and be it further

RESOLVED, that KMA continue its unrelenting efforts to focus its legislative efforts to effect health care reform that promotes high quality patient care through effective use of physician resources.

## **RESOLUTION T**

### **Physician Assistants**

**Thomas M. Adams, MD**

WHEREAS, the Kentucky Medical Association, American Medical Association, American Academy of Family Physicians, Kentucky Academy of Physician Assistants, and the American Academy of Physician Assistants have each recently reaffirmed their understanding of Physician Assistant practice as requiring the supervision of licensed physicians; and

WHEREAS, the Kentucky Board of Medical Licensure credentials Physician Assistants for practice in Kentucky as certified rather than licensed health care providers; and

WHEREAS, the majority of states credential Physician Assistants as licensed health care providers who are required to practice with the supervision of licensed physicians; and

WHEREAS, the qualifications and training credentials for certified and licensed Physician Assistants are the same; and

WHEREAS, a variety of state, federal, and institutional regulations and policies regarding credentialing of health care professionals require licensure status for purposes of staff privileges and reimbursement to the practice in which the Physician Assistant functions; and



WHEREAS, many Kentucky physicians are prevented from effectively utilizing the services of Physician Assistants due to barriers encountered in obtaining staff privileges and reimbursement for Physician Assistants' services now, therefore, be it

RESOLVED, that the Kentucky Medical Association endorses legislation that credentials Physician Assistants in Kentucky as licensed health care providers who are required to practice with the supervision of licensed physicians; and be it further

RESOLVED, that the Kentucky Medical Association endorses legislation, regulations, agency and institutional policies that authorize that health care services provided by Physician Assistants be reimbursed to the practice in which the Physician Assistant functions.

#### Recommendations, Reference Committee 1:

The Reference Committee reviewed Resolution T, Physicians Assistants, introduced by Thomas M. Adams.

The Reference Committee recommends that the first Resolved of the Resolution be deleted and that the second Resolved be amended by deleting the words "practice in which" and substituting for them the phrase "physician who supervises" and by deleting at the end, the word "functions." The amended second Resolution would then read as follows:

**RESOLVED, that the Kentucky Medical Association endorses legislation, regulations, agency and institutional policies that authorize that health care services provided by Physician Assistants be reimbursed to the practice in which physician who supervises the Physician Assistant functions.**

The Reference Committee recommends that Resolution T be adopted as amended.

Mr Speaker, Reference Committee No. 1 recommends the adoption of this report as a whole, as amended.

Mr Speaker, I want to thank the members of Reference Committee No. 1 who worked hard to assist the House of Delegates on these matters. Other members of the Committee were: John V. Borders, MD, Lexington; Deborah L. Copeland, MD, Louisville; Robert Emslie, MD, Bowling Green; John M. Patterson, MD, Frankfort; John D. Stewart, II, MD, Lexington. I also wish to thank Debbie Sabrie for her help and guidance in preparation of this report.

Respectfully submitted,  
REFERENCE COMMITTEE NO. 1  
Susan Berberich, MD, Louisville, Chair  
John V. Borders, MD, Lexington  
D. Lee Copeland, MD, Louisville (RPS)  
Robert Emslie, MD, Bowling Green  
John M. Patterson, MD, Frankfort  
John D. Stewart, II, MD, Lexington

*Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.*

## REPORT OF REFERENCE COMMITTEE NO. 2

Baretta R. Casey, MD, Pikeville, Chair

14. Report of the Scientific Program Committee
15. Report of the Scientific Exhibits Committee
16. Report of the Continuing Medical Education Committee
17. Report of the Council for Continuing Medical Education
18. Report of the Cancer Committee
19. Report of the Physician Workforce Committee
20. Report of the Hospital Medical Staff Section
21. Report of the Rural Kentucky Medical Scholarship Fund

Resolution K — Advance Directive Forms

(Jefferson County Medical Society)

Resolution M — Socioeconomic Curricula for In-Training Physicians  
(Young Physicians Section)

Resolution Q — Kentucky Organic Growers  
(Estill County Medical Society)

Resolution R — Optometrists as Primary Care Providers  
(Fayette County Medical Society)

#### ITEMS FOR CONSENT

Reference Committee No. 2 reviewed the following items and recommends they be filed, by consent of the House, without discussion:

16. Report of the Continuing Medical Education Committee — filed
17. Report of the Council for Continuing Medical Education — filed

Mr Speaker, Reference Committee No. 2 recommends adoption of the Consent Calendar as a whole.

## Report of the Continuing Medical Education Committee

The work of the Continuing Medical Education Committee continues to increase. The committee met on a quarterly basis this year and is planning its annual seminar on the continuing medical education accreditation process for the fall of 1995. Since the promulgation of mandatory continuing medical education for physicians as a condition of licensure, the activity of the committee has increased as the number of organizations which the committee accredits as providers of continuing medical education has tripled over the last two years. As a result, the committee conducted numerous surveys and resurveys of institutions which applied for accreditation of their CME programs. The committee serves as the accreditation arm of KMA's CME efforts. In this role, the committee assists organizations in developing effective CME programs and then monitors organizations' programs through formal surveys. After the surveys, the committee, in most cases, grants accreditation to organizations so they can, in turn, conduct individual CME programs. Due to the increase in accredited sponsors, the committee would like to encourage additional KMA members to take an active interest in the proceedings of the committee and assist in accreditation efforts by serving as site team surveyors.

Surveys were conducted for five institutions which had applied for reaccreditation. All five organizations applying for reaccreditation were approved and granted accreditation periods up to four years based on their ability to meet the criteria of the KMA Essentials, which all organizations must demonstrate to become accredited. In addition to the resurveys of previously accredited organizations, eight new organizations submitted applications and were granted surveys. All eight applicants were approved and granted up to a two-year provisional accreditation period, with an interim report to be filed at the midpoint of the accreditation cycle.

The initial accreditation process assumes six steps. First, an organization submits a preliminary questionnaire to the KMA Headquarters Office. When the preliminary questionnaire is deemed appropriate, the organization submits an application to the KMA; the survey team then reviews the application and determines if the organization is ready for a survey; a survey is conducted; the survey team formulates a survey report with suggestions for improvement to the organization, as well as a recommendation regarding the accreditation period to the CME Committee; and the survey report is subsequently voted on by the committee as a whole. After the committee approves an accreditation status, it notifies the organization and informs the organization of the accreditation period. The reapplication process is essentially the same format without the preliminary questionnaire. The committee also requires an interim report from the organization at the midpoint of the accreditation period so the committee can continue to monitor and assist the organization between surveys.

The committee undergoes a similar survey and interim report process through the Accreditation Council on Continuing Medical Education (ACCME). In this survey process, the ACCME recognizes state medical societies as accreditors of organizations who develop continuing medical education programs. To this end, the Kentucky Medical Association is the only official accreditor of CME organizations in Kentucky. The committee was resurveyed in July 1993 and was informed of its recognition status in October 1993. An interim report was filed to the ACCME in July 1994, and a response from the ACCME in October of 1994 noted that the ACCME Committee on Review and Recognition accepted the KMA's interim report and commended the CME Committee for its efforts to address previous areas of concern and its continued work to maintain a strong program.

The CME Committee continues to implement the suggestions of the ACCME including: mailing a CME newsletter to all accredited organizations





on a quarterly basis; accrediting organizations up to four years for full accreditation and first time applicants up to two years; offering a consultation service if organizations need additional assistance in establishing a CME program; and offering an expanded seminar with breakout sessions for different tracks based on the knowledge level of CME personnel in Kentucky.

One new policy implemented this year by the committee was on hospital mergers. The committee noted that due to the changing nature of the health care delivery system, health care organizations are looking into mergers and buyouts to consolidate services and make health care delivery more efficient. Because the KMA accredits organizations to provide continuing medical education, mergers and buyouts can significantly affect the status of a particular organization's CME program. As a result, the committee formally approved policy that it is the responsibility of the accredited organization to notify the KMA if significant changes have been made to its program as a result of a merger or a buyout. The CME Committee will make this policy known to all accredited organizations in Kentucky through its *CME Quarterly* newsletter, through the notice to the organizations when the interim report is due, and a question on the Application for Accreditation for CME.

The committee developed a CME recordkeeping folder which allows physicians licensed in Kentucky to keep track of continuing medical education credits earned during the year. The folder is mailed to all KMA member physicians.

The committee continues to have input at the national level regarding CME. Robert R. Goodin, MD, updates the committee regularly on the business of the AMA Continuing Medical Education Advisory Committee, which he was appointed to in 1992. Staff again attended the annual ACCME/State Society CME meeting in Chicago in September. The ACCME uses the meeting with representatives of the state societies to provide new information on changes in policy on CME and discuss any problems or concerns which states may see in the CME accreditation process. Major items of discussion at the conference were hospital mergers and information of consortia due to the rapidly changing nature of the health care environment; the acceptance of commercial support from pharmaceutical and the medical equipment industry; and the process for complaints/inquiries concerning intrastate sponsors.

The committee continued its annual solicitation for nominees for the Educational Achievement Award. Since the committee revised the criteria and the selection process three years ago, the number of nominations has increased annually. Nine nominations were received and considered by the committee. One recipient was selected by the committee. The recipient was Richard W. Schwartz, MD, a Lexington surgeon.

The committee continues to oversee the implementation of Resolution J from the 1992 House of Delegates on mandatory CME for physicians as a condition of licensure. The resolution was considered by the Kentucky Board of Medical Licensure and implemented into a regulation on mandatory CME for physicians in October 1993 and became effective on January 1, 1994, with the beginning of the annual license renewal period for physicians. The regulation requires that all licensed Kentucky physicians obtain 60 hours of continuing medical education credits within a three-year period. Of the 60 hours, 30 of the hours must be in Category 1 credit, and 2 hours must be obtained from a Cabinet for Human Resources-approved HIV/AIDS Training Course. The committee will continue to monitor the regulation and forward information to the Kentucky Board of Medical Licensure if any changes are undertaken that would affect the nature of CME.

At the last meeting of the year Thomas K. Slabaugh, MD, took over as the new chair of the committee, replacing W. David Hager, MD. Dr Hager chaired the committee for two years and was instrumental in seeing the committee receive a four-year accreditation by the ACCME at its survey in July 1993. Dr Hager also oversaw the implementation of several improvements to the Kentucky Medical Association's CME program such as the Policy and Procedure Manual, the *CME Quarterly* newsletter, and the consultation service available to organizations in Kentucky.

Finally, the committee revised the application for accredited sponsors of continuing medical education. The committee added a new section to the application on the Standards for Commercial Support since all accredited organizations must maintain compliance with the Standards. The new section asks that organizations document the process used in working with industry in acceptance of support for educational programs. A question under Essential #6 asks that organizations have input from a representative

from the quality assurance/quality improvement department.

The committee has an additional meeting scheduled for September and anticipates another busy year in 1995-96.

**Thomas K. Slabaugh, MD**  
Chair

## Report of the Council on Continuing Medical Education

The Council on Continuing Medical Education met on two occasions this year, with both meetings held jointly with the CME Committee.

Since the Council on Continuing Medical Education serves as the provider of CME for the Association, it focuses much of its efforts on the Annual Scientific Program. The council reviewed the theme, "FUTURECARE," and the draft of the program for the 1995 KMA Annual Meeting from the work of the Scientific Program Committee. The council reviewed evaluation forms from the 1994 Annual Scientific Session, as well as 1995 Scientific Program speakers, topics, and objectives.

The council is accredited by the Accreditation Council on Continuing Medical Education (ACCME) to provide continuing medical education for physicians in Kentucky. The council submitted an application to the ACCME for reaccreditation in April since its four-year accreditation period, granted in 1991, expired this year. The survey took place in June and it is expected that a decision from the ACCME will be forthcoming in September or October concerning the new accreditation status. The accreditation status is expected to be favorable as several updates have been made to the work of the CME Council since its last survey by the ACCME in 1991, including a revision of the mission statement, revision of the policy on joint sponsorship, and designation of CME credit for programs of the KMA other than the Scientific Program of the Annual Meeting. In its application to the ACCME, the council noted that better efforts are being made at needs assessment, development of learning objectives, and documentation of all phases of the planning steps as required under the "ACCME Essentials and Guidelines of Continuing Medical Education." In addition, all appropriate forms are used in acceptance of commercial support for programs as required under the "ACCME Standards for Commercial Support."

The council, having revised its joint sponsorship policy, agreed to jointly sponsor a program of the Kentucky Medical Review Organization on "Substance Abuse in the Elderly." The program was held on December 8 in Lexington, and was attended by over 40 physicians. Staff worked closely with representatives of the Kentucky Medical Review Organization in conducting the program. The council's approval for joint sponsorship was on a one-time basis, and the council recommended that the Kentucky Medical Review Organization work toward a separate accreditation under the CME Committee.

The council worked with different committees of the Association to plan and designate educational activities for AMA PRA Category 1 and 2 credit. The Hospital Medical Staff Section of the Association submitted a need to the council to hold a seminar on new trends in managed care. After assessing an appropriate need for the seminar, the council assisted in planning the program with representatives of the Hospital Medical Staff Section (HMSS) and designated the seminar for four hours of Category 2 credit. The HMSS meeting was attended by over 35 physicians.

The council considered the need for a seminar from the Subcommittee on Domestic Violence for physicians on domestic violence awareness. The council approved the need for the seminar and worked closely with representatives from the Subcommittee on Domestic Violence to plan the seminar on domestic violence issues scheduled for May 20, 1995. Due to unforeseen circumstances, the seminar was canceled.

Although serving as site surveyors for organizations accredited by the KMA is not the responsibility of the Council on Continuing Medical Education, most members of the council volunteered their time and served as site surveyors for organizations submitting applications for accreditation under the auspices of the CME Committee. Serving as a site surveyor is an effective way to stay current on the accreditation process as well as oversee the important steps of the Essentials that all organizations, including the KMA, must maintain in planning continuing medical education activities. The CME Council will also work closely with the CME Committee to sponsor



the annual "CME Accreditation Process Seminar" which will probably be held late in the fall of 1995.

During the coming year, the council will continue to judiciously address requests for joint sponsorship from nonaccredited organizations, and will work to fulfill the recommendations of the ACCME to maintain a high level of quality continuing medical educational offerings in Kentucky.

The council would like to thank the Board of Trustees for being permitted to serve, and looks forward to expanded activity in 1995-96.

**James L. Borders, MD**  
Chair

## END OF CONSENT CALENDAR ITEMS

### Report of the Scientific Program Committee

"FUTURECARE" was selected by the Scientific Program Committee as the overall theme for the 1995 KMA Annual Meeting Scientific Program. Each morning session will focus on the theme from the perspective of the various specialties participating in the meeting. The committee members and representatives of the planning committee from the 23 specialty societies have worked hard to bring some of the United States top speakers to the meeting, and it is hoped that the membership will find their presentations practical and helpful.

The Scientific Program was planned last fall and a meeting was held in December with the presidents and/or representatives of the 23 specialty groups that will participate in the annual session. Specialty groups' scientific programs held in conjunction with the morning general sessions have proven to be very popular, and provide an excellent source to the continuing medical education of the membership. I personally appreciate the excellent cooperation the committee has had from all of the specialty societies in planning the overall meeting, and I thank them for their suggestions and assistance, and encourage them to continue to assist the committee in finding new and innovative ideas for topic selection and presentation.

The 1994 Annual Meeting was held at the Hyatt Regency Hotel/Convention Center, with an attendance of 2,497 total attendees.

Exhibitors were asked to fill out evaluation forms on Tuesday, Wednesday, and Thursday during the 1994 meeting. This allowed a better assessment of exhibitors' viewpoints and new ideas which they may have for improving the meeting to be considered by the Scientific Program Committee. The exhibitors' comments were, overall, positive.

Results from physicians' evaluation forms from the general sessions and specialty group meetings were again positive and revealed that physicians attended the 1994 Annual Meeting program because of the availability of Category 1 CME credit, a friendly learning environment, speaker quality, and the overall program content.

The Kentucky Medical Insurance Company will again sponsor a Risk Management Workshop for Office Assistants, as well as a separate workshop for physicians. In addition to the regular general sessions program, the committee again has developed a two-hour HIV/AIDS course for physicians. Ardis D. Hoven, MD, KMA Immediate Past President, has again been instrumental in planning a top-notch program which will be offered for two hours of AMA PRA Category 1 credit. The course has also been approved by the Cabinet for Human Resources and meets the requirements of the mandatory CME regulation for physicians. Due to the overwhelming response and attendance at last year's HIV/AIDS program, the program will be held again for this year's Annual Meeting.

The 1995 KMA Annual Meeting will be held at the Hyatt Regency Hotel/Civic Center in Lexington. Meetings of the KMA Board of Trustees, House of Delegates, Reference committees, KEMPAC, and Alliance, as well as various food functions, will be held in the Hyatt Regency Hotel. General registration, specialty group meetings, general sessions, and the technical exhibit hall, as well as scientific and education exhibits will be located in the Civic Center. We urge members and their staffs to visit the exhibits. These informal contacts offer numerous opportunities, education reviews, and discussion of new products and familiarization with new equipment, free from the interruptions or distractions of the office or hospital.

The revised format for the general sessions will be used again this year. General scientific sessions will be held on Tuesday and Wednesday mornings, and specialty groups will meet on Tuesday and Wednesday afternoons and Thursday morning. For the past several years, attendance for the

Thursday morning general session had been very low, with out-of-state visiting guest speakers addressing few people in the audience. In addition, specialty groups meeting on Thursday afternoon continued to express concern to the committee that by the time their meetings were held, many of the exhibitors had dismantled their displays. In review of the format for the 1995 Annual Meeting, the committee agreed that last year's format worked well for all involved parties and approved the format again for the 1995 meeting.

The scientific sessions are again designated for AMA PRA Category 1 continuing medical education credit and are also approved for prescribed credit by the American Academy of Family Physicians.

As always, I am very grateful for the efforts of all those individuals who have assisted in the formation of another outstanding program, particularly the Program Committee, specialty group presidents, and program chairs. Suggestions for future programs are always welcomed by the Scientific Program Committee.

**Sonia R. Teller, MD, PhD**  
Chair

### Recommendations, Reference Committee 2:

Reference Committee No. 2 reviewed the Report of the Scientific Program Committee. The Committee would like to commend Sonia R. Teller, MD, for her hard work and service to the Scientific Program Committee and recommends Report No. 14 be filed.

### Report of the Scientific Exhibits Committee

Although the Scientific Exhibits Committee does not meet formally, the work that is put into the scientific exhibits area continues to be a vital and integral part of the overall success of the Annual Scientific Meeting. The activities of the committee are carried out by mail and telephone. We notify members through the *Journal of the Kentucky Medical Association* and the *KMA Communicator* of the availability of space and provide applications to interested individuals. In 1994, five outstanding scientific exhibits were approved by the Scientific Exhibits Committee. We also provide exhibit space for entities such as the Impaired Physicians Program. We wish to express our appreciation to the following exhibitors at the 1994 Annual Meeting:

- *Kentucky Cancer Program*  
Ms Connie Sorrell
- *Spinal Disorders — A Quiz for the Practitioner*  
John J. Vaughan, MD; H. Brooks Morgan, MD; Marion Bruestle, RN
- *Creation of a Fourth Year Medical School Rotation in Emergency Medicine*  
Department of Emergency Medicine, University of Kentucky
- *Abdominal Aortic Aneurysm: Diagnosis and Management*  
Sibu P. Saha, MD; Anthony G. Rogers, MD; Gary F. Earle, MD; A. Brian Wilcox, MD
- *Macular Degeneration "The Good, The Bad, The Ugly"*  
Charles F. Mahl, MD; Steven M. Bloom, MD; Sean F. Murphy, MD; Larry J. Alexander, OD; John E. Musick, OD

We would also like to congratulate the Kentucky Cancer Program which is the recipient of the 1994 Award of Excellence.

I want to take this opportunity to thank the members of the committee for their dedication in serving on the Scientific Exhibits Committee. The scientific exhibits area continues to be a significant and substantial portion for the exchange of necessary and practical scientific information at the Annual Scientific Meeting, and we feel that it is worth all physicians' time to stop at the scientific exhibits area during the Annual Meeting and visit with the scientific exhibitors.

**Richard A. Kielar, MD**  
Chair

### Recommendations, Reference Committee 2:

Reference Committee No. 2 reviewed the Report of the Scientific Exhibits Committee. Reference Committee No. 2 would like to recommend that increased participation as well as guidelines for the development of Scientific Exhibits be encouraged by wider dissemination of information to potential participants. The Reference Committee recommends that Report No. 15 be filed.





## Report of the Cancer Committee

The Cancer Committee met on two occasions this year to address current concerns in the field of cancer treatment in Kentucky.

The committee has proposed several ongoing projects that will encompass time and research on behalf of its members. As a result, the committee has scheduled meetings every quarter.

One project being researched by the committee is an informational booklet on options for treatment for prostate cancer. While various sources of information are available, it was noted that it is not always accessible to patients. The committee has looked at information from the Kentucky Cancer Registry, the National Cancer Institute, and the Commission on Cancer. The information will be addressed at additional meetings of the committee in development of a KMA educational booklet on treatment of prostate cancer.

Another project which has received ongoing attention and analysis is a study of the number of radical and modified radical mastectomies being performed in Kentucky. It was noted that review organizations are monitoring the number of mastectomies performed in Kentucky, and evidence indicates that the number of mastectomies, as compared to other treatments such as tylectomies or lumpectomies, is approximately 10 to 1, which is thought to be an inordinate number. While others are evaluating Medicare data, the goal is to study the information from the committee's standpoint to see why the disparity exists.

In researching the disparate rates, Gary Vitale, MD, designed a Mastectomy vs Breast Conservation Questionnaire to use as a resource to see why patients were choosing mastectomies over lumpectomies. The first step of the survey will be to choose a small subset of a few hundred patients treated in one quarter of the year so that a 90% response rate could be achieved. Once the first phase of the survey is complete, the number surveyed will be expanded to include evaluation of the total patient history to determine the total number of operations a patient had and the results of pathology reports. Once the comprehensive survey is compiled, it will be sent as a combined survey of the Kentucky Medical Association, the University of Louisville, and the University of Kentucky.

In addition to Dr Vitale's survey, Gil Friedell, MD, Director, Markey Cancer Center, reported to the committee regarding the information compiled by the Kentucky Cancer Program and the Kentucky Cancer Registry. In general, the Kentucky Cancer Registry holds periodic information and training programs to assist hospitals in reporting uniformly cases of cancer incidence. Cancer incidence reports are published annually, with each report examining previous year's cancer incidence rates by county and area development district. This information will be useful in compiling the study on mastectomy and breast conservation.

Dr Friedell also addressed the committee regarding the resources available through the Kentucky Cancer Program and Kentucky Cancer Registry. Dr Friedell distributed the biennial report of the Kentucky Cancer Program and the Kentucky Cancer Registry 1993 Cancer Incidence Report. The Kentucky Cancer Program is a joint effort of the cancer centers of the University of Kentucky and the University of Louisville, and has three divisions: the Cancer Information Service, Community Programs, and the Kentucky Cancer Registry. The three divisions function as a team to provide data-based information about cancer to the public and to health care professionals throughout the state.

In April 1990, legislation was passed which formally established the Kentucky Cancer Registry (KCR) as the population-based central cancer registry for the state. The legislation mandated the reporting of all cancer cases to the registry, and was amended in 1994 to include mandatory reporting by all health care facilities in the state.

The 1993 Cancer Incidence Report is divided into three sections. The first section contains an overview of the characteristics of cancer patients diagnosed in Kentucky during 1992 and 1993. The 1992-93 age-adjusted rates for Kentucky are compared to the age-adjusted cancer incidence rates of the National Cancer Institute's Surveillance, Epidemiology and End Results (SEER) Program. The second section provides detailed information on specific types of cancer. The last section contains technical notes regarding methodology.

All 109 acute hospitals in the state and their associated outpatient facilities actively participate in the system. The 47 larger hospitals (those seeing more than 100 new cancer cases annually in either their inpatient

or outpatient facilities) have their own cancer registrars, and each hospital-based registrar has received formal training from the KCR staff. Registrars at the larger hospitals identify each case of cancer and enter the data into a computer software program (Cancer Patient Data Management) developed by the KCR. This software is also used to edit the data, follow each new case of cancer, create reports of the hospital's cancer care activities, and conduct studies for the medical staff. The hospital registrars are assisted by three KCR regional coordinators with case finding audits, abstracting audits, cancer program development, continuing education programs, and preparation for American College of Surgeons' cancer program approval.

Data regarding the cancer cases seen at the 62 hospitals (those seeing 100 new cases of cancer or less every year in their inpatient and outpatient facilities) is gathered by three KCR regional abstractors. The gathered data is entered into a computer at the central registry, located at the Markey Cancer Center in Lexington.

Dr Friedell stated that the Kentucky Cancer Registry has recently applied for a federal grant from the Centers for Disease Control to enhance the statewide registry. If awarded, this grant will enable the KCR to improve the quality and completeness of its database. Additional personnel will be employed to abstract cases seen in non-hospital health care facilities, as well as perform quality assurance procedures, and conduct special epidemiological studies.

Dr Friedell pointed out to the committee that the Kentucky Cancer Registry has a Home Page on the Internet, and noted that the server provides direct access to all data published in the annual reports to the Governor and General Assembly of Kentucky. The goal of the Kentucky Cancer Registry is to provide resource data which public and private agencies can use to understand the incidences of cancer throughout the state, as well as a prime educational service to hospital medical staffs.

The committee discussed the recent announcement that the Health Care Financing Administration has initiated a nationwide public information campaign to encourage women aged 65 and older to get a Medicare-covered mammography. In regard to this issue, the Cancer Committee approved the following recommendation:

The Cancer Committee recommends that the KMA, in conjunction with appropriate specialty groups, support HCFA's efforts on a statewide basis to ensure that all eligible women receive mammography.

The committee will continue its study and research into cancer issues at subsequent meetings. The committee looks forward to continued activity and would like to thank the Board for being permitted to serve.

**Harry W. Carloss, MD, FACP  
Chair**

### RECOMMENDATION:

1. The Cancer Committee recommends that the KMA, in conjunction with appropriate specialty groups, support HCFA's efforts on a statewide basis to ensure that all eligible women receive mammography.

### Recommendations, Reference Committee 2:

Reference Committee No. 2 reviewed the Report of the Cancer Committee and its Recommendation and suggests the Recommendation be revised as follows:

The Cancer Committee recommends that the KMA, in conjunction with appropriate specialty groups, support HCFA's effort on a statewide basis to ensure that all eligible women receive mammography *at a certified unit*.

Reference Committee No. 2 recommends the Report of the Cancer Committee be adopted and that its Recommendation #1 be adopted, as amended.

## Report of the Physician Workforce Committee

The Physician Workforce Committee met on one occasion to review several issues in medicine that will impact physician workforce.

The committee addressed AMA Resolution 307 adopted at the Interim Meeting in December 1994. Resolution 307 encourages state medical societies, in conjunction with primary care specialty societies, to promote and encourage primary care internship and/or preceptorship programs for medical students in their states as a positive means toward increasing the number of primary care physicians.

Representatives from the University of Louisville and the University of Kentucky medical schools felt it would be a good idea to develop an



organized "shadowing" experience for medical students and possibly premed students. One study showed that premed students who had some type of medical work experience do better in medical school. Medical students and pre-meds are always looking for work experience in a patient care setting.

The committee discussed the program of the American Medical Student Association which offers a stipend for summer preceptorships in Health Promotions and Disease Prevention called "Hip Dip." More information will be gathered about the program and will be sent to the medical schools in Kentucky to help make students aware of the program.

The committee discussed that AMA Resolution 307 is similar to Resolution E adopted by the 1992 KMA House of Delegates, which was implemented by the committee in 1993-94. Resolution E encouraged the KMA to work with the primary care specialty societies and the medical schools to continue to encourage the specialty groups to assist medical students in getting work experience in physician offices. The committee will continue to encourage the primary care specialty societies and the medical schools to work together in coordinating preceptorships, and it will also help make it known that, in limited cases, financial support is available for students through programs such as "Hip Dip."

A letter will be sent to each primary care specialty group and an article will be placed in the *Communicator* encouraging physicians to participate in preceptorship programs.

Another program in Kentucky which helps the distribution of the physician workforce in Kentucky is the Rural Kentucky Medical Scholarship Fund (RKMSF). At a previous meeting, the committee had made recommendations to the Board of Directors of the RKMSF which included revising the designation criteria guidelines to be consistent with those of the National Health Service, and using the RKMSF funds for matching funds under the "state loan repayment program." KMA staff for the RKMSF reported on the recommendations and noted that the RKMSF has been a very successful program that helps place physicians in rural Kentucky primary care settings through medical school loans and practice start-up grants. However, over the past few years, the market has become more competitive with numerous other sources of available scholarships. Mr Dave Carby, KMA staff for the RKMSF, noted that the RKMSF's criteria for awarding scholarships to recipients have remained the same for a number of years and are based on a physician-to-population ratio by county. As a result, the number of scholarship applicants has steadily declined.

Consequently, the Scholarship Fund Board of Directors appointed a subcommittee to explore ideas for restructuring the eligibility criteria for receiving a scholarship. As a result of its meetings, the subcommittee will be making recommendations to the full Board of the Rural Kentucky Medical Scholarship Fund at its summer meeting.

The recommendations from the subcommittee go beyond the National Health Service criteria to make the RKMSF more competitive. As a result, they are proposing incorporating several identifiers used by the federal government, including revising the RKMSF criteria to take into account the percent of population below the poverty level in a county; infant mortality rate; hospital/medical clinic population in a given county; percent of population over 65 years of age; and percent of population with high school degrees. All these different factors are weighed to come up with a formula, and the subcommittee is recommending that the Scholarship Fund accept this new weighted criteria that will broaden the standards and put the fund much more in line with the federal designation criteria.

In addition to the new criteria, the RKMSF will still keep the rural county/critical county designation. Under the critical county criteria, the RKMSF would award a pure scholarship to recipients so that if a recipient serves his/her time in a critical county, no repayment would be required. The rural county criteria would remain the same, in that it would be a low interest loan to help fund the cost of medical education. This will make the scholarships more competitive and more attractive to medical students.

It was also reported that RKMSF is looking at and possibly going to revise the criterion requiring that a recipient live and work in the same county. The RKMSF Board is also going to consider raising the loan amount for recipients from \$10,000 to \$12,500 per year.

In terms of using RKMSF funds for matching grants, the Scholarship Fund is in good financial condition and wants to do everything it can to encourage primary care physicians to locate in underserved areas in Kentucky, and has broad discretion on how to utilize the funds in its care.

While the subcommittee has not specifically discussed this recommendation, it will be discussed at future meetings.

The committee noted that some provisions enacted under HB 250 from the 1991 General Assembly are close to implementation. The medical education reform section calls for the creation of regional family practice residency training programs in community-based sites, coordinated so that the number of first-year postgraduate positions in family practice is comparable to the number of graduates entering family practice. Representatives from the medical schools reported that five out of six of the sites have been established, with one in the Sixth Congressional District yet to be finalized.

HB 250 also calls for non-primary care residency spots to be capped at the 1994 level with the goal being to encourage more primary care physicians to practice in Kentucky. It was reported that graduates in primary care from both medical schools are up well over 50%, so the transition of capping non-primary care residency spots has been a smooth one.

Finally, the funding for the Kentucky Health Service was discussed. The Kentucky Health Service was established through the medical schools to provide funds for medical students and residents to practice primary care for one (1) year for each year of participation in the service. The committee noted that this program is still in its infancy stages due to lack of funding for the program.

In addition to HB 250 having an impact on physician workforce, recently passed federal legislation will allow for each state to get 20 waivers each to place international medical graduates who have completed J-1 Visa training in extremely underserved areas. The 20 physicians placed must agree to practice primary care for a three-year commitment. Ms Jan Hurst, U of L Physician Placement Service, reported that she is working with the Cabinet for Human Resources to oversee the program in Kentucky and ensure that the best candidates are selected.

The discussion of the J-1 Visa program led to discussion of the international medical graduates (IMGs) residency positions in the United States. Dr Goodin remarked that a recent *JAMA* article brought the issue to the forefront, and it will receive significant attention at the national level by the AMA. The *JAMA* article calls for examining the national IMG policy in light of the projected physician surplus in the United States. In 1963, IMGs represented slightly more than 10% of the physician workforce, by 1970 that percentage had increased to nearly 18%. Today, IMGs comprise nearly one fourth of US physicians. In comparison to United States medical graduates (USMGs), since 1980, the annual number of USMGs has remained steady at approximately 17,000, while in recent years, the number of IMGs in graduate medical education has increased. The article concludes that a long-term solution for the number of physicians in practice, USMG or IMG, is a system of specifying the number of GME positions nationally. The committee will continue to address this issue at subsequent meetings.

The committee would like to thank the Board of Trustees for being permitted to serve, and looks forward to continued work in 1995-96.

**Gorden T. McMurry, MD**  
Chair

#### **Recommendations, Reference Committee 2:**

Reference Committee No. 2 reviewed the Report of the Physician Workforce Committee and would like to acknowledge programs which are presently in force by the Kentucky Academy of Family Physicians, including the Adopt-A-Student program and Shadowing. The Reference Committee would like to commend the Kentucky Academy of Family Physicians for their efforts and recommends that Report No. 19 be filed.

#### **Report of the Hospital Medical Staff Section**

The Hospital Medical Staff Section (HMSS), established in 1984 to provide a forum for discussion of mutual problems of hospital medical staffs, continues to see increased participation by hospital medical staff representatives in activities of the section.

The HMSS Steering Committee, elected by the section members, works toward planning education programs and other activities that provide physicians with information that is vital in both their individual practices and their function as members of the medical staff of their hospitals. The Steering Committee met formally several times during the year to plan its 1994-95 annual meeting. This annual meeting was held on Saturday, November 19, 1994, at the Alliant Medical Pavilion in Louisville.





The section was honored to have present at its annual meeting a distinguished faculty of presenters. These presenters included: Robert Goodin, MD, KMA President; William Monnig, MD, Past KMA President and AMA-HMSS Governing Council; William Jessee, MD, Senior Medical Officer, Alliant and Baptist Healthcare; Diane Kolb, The Physicians Inc; Russ Fendley, Kentucky TotalCare; and Sal Barbera, Alliant. Topics of discussion at the annual meeting included JCAHO, medical staff governance, credentialing, and various managed care topics. The KMA-HMSS Steering Committee continues to meet on a regular basis to plan the 1995-96 annual meeting. This meeting is scheduled to be held on Saturday, October 28, 1995, at Carter Caves Resort State Park in Olive Hill, Kentucky. Please make plans to attend this meeting.

A number of KMA-HMSS members attended the AMA-HMSS meetings in December 1994 and June 1995. A major topic of discussion at these meetings was the plan to change the section name from the Hospital Medical Staff Section to the Organized Medical Staff Section. It is hoped that this change will allow for physicians providing care in emerging nontraditional delivery systems to be effectively represented by organized medicine. The KMA-HMSS will study this transition at the AMA level to determine if the same is warranted in Kentucky. Obviously, KMA Board of Trustee and House of Delegate approval would be needed for such a change. This section will report back on this issue in next year's report.

Other items of importance discussed by the Section during the past year included the release of medical malpractice data by the Kentucky Department of Insurance to any inquiring person or entity and development of practice parameters by the Kentucky Health Policy Board.

The House of Delegates in 1994 passed Resolution B appointing the KMA-HMSS as a repository for verified instances of economic credentialing. To date, the HMSS has received no information from any Kentucky physician reporting an instance of economic credentialing.

I would like to thank the members of the 1994-95 HMSS Nominating Committee for their dedicated work in selecting candidates for Steering Committee positions. The members of the Nominating Committee are Kenneth E. Green, MD, Leitchfield; Robert J. Emslie, MD, Bowling Green; William D. Pratt, MD, London; H. Michael Oghia, MD, Russell Springs, John D. O'Brien, MD, Louisville; and David Krasnopolsky, MD, Hazard.

As Chair of the KMA Hospital Medical Staff Section, I would like to take this opportunity to express appreciation to medical staffs and section representatives of those hospitals who have chosen to participate in the KMA-HMSS. I am also grateful for the dedication of the members of the 1994-95 Steering Committee for their efforts to make the HMSS an effective KMA activity. Those members are Kenneth E. Green, MD, Leitchfield, Vice Chair; Rex Cox, MD, Louisville, Secretary; William D. Pratt, MD, London, Delegate; H. Michael Oghia, MD, Russell Springs, Alternate Delegate; and Robert Emslie, MD, Bowling Green, and William Albert, MD, Russellville, Members at Large.

The HMSS will continue working toward its goals of having active participation from the medical staff of each eligible hospital in Kentucky and providing whatever assistance it can to medical staff members. This is a positive step toward assuring good working relationships between physicians and hospitals, and I urge each physician to see that the medical staff of his/her hospital becomes actively involved in the KMA and AMA Hospital Medical Staff Sections.

**John D. O'Brien, MD**  
Chair

#### **Recommendations, Reference Committee 2:**

Reference Committee No. 2 reviewed Report No. 20 and would like to recommend that there be increased participation and support by organized medical staffs to the Hospital Medical Staff Section. The Reference Committee recommends that Report No. 20 be filed.

### **Report of the Rural Kentucky Medical Scholarship Fund, Inc**

The Rural Kentucky Medical Scholarship Fund, Inc, (RKMSF) attempts to meet the medical needs of the rural population by alleviating the maldistribution of physicians in Kentucky. RKMSF currently administers two worthwhile programs in its efforts to meet this goal.

The first program provides low interest loans to medical students. Any

loan recipient who practices primary care medicine in a county in critical need of physicians will be forgiven one loan for each full year of practice in the approved county. Any recipients practicing in a designated rural county facing a primary care physician shortage which is less than critical must repay their loans at a discounted interest rate which is determined yearly. Interest accrues from the date of the loan until payment is due.

For the school term 1995-96, the RKMSF offered scholarship loans to 13 new applicants in the amount of \$10,000 each, and 10 loans to prior student recipients, said loans totaling \$230,000. Last year a total of \$190,000 was expended in scholarship loans. In 1993-94, \$230,000 was expended.

Since its inception in 1946, the Rural Kentucky Medical Scholarship Fund has granted approximately 600 loans. There are currently 50 medical students/residents who have received loans from the RKMSF and completed their financial obligations. The loans are granted for an eight-year period. In 1995-96, 11 recipients are entering primary care residency programs, 13 recipients are currently enrolled in residency programs, and 3 recipients are entering the full-time practice of medicine in 1995. There were 3 recipients who received forgiveness for loans in 1994-95, and 3 recipients completed their financial and/or practice obligations in 1994-95.

The second program administered by RKMSF is the Establish Practice Grant Program (EPGP). The EPGP provides money to practicing physicians to assist in paying prior educational loans. For each year a physician in the EPGP practices in a critical county, they will be granted \$10,000 to be used toward an educational debt, with a maximum of \$40,000 granted per physician.

Two physicians are currently participating in the EPGP. Since its inception in 1989, there have been a total of 9 participants in the EPGP. Currently, there are 3 vacancies in the Establish Practice Grant Program.

The 1996-97 educational year will bring some changes to the RKMSF. In an effort to make the Fund more competitive with existing marketplace loans and opportunities, the Board of Directors recently approved new critical/rural county designation identifiers which should add some stability to the county designation process. Under these changes, 45 counties will be designated as critical and 40 as rural. Additionally, during 1996-97, the loan amount will be increased from \$10,000 to \$12,000. It is hoped these changes will help the RKMSF continue to grow and comply with its mission statement of placing primary care physicians in underserved areas of Kentucky.

The RKMSF has two main sources of income: interest accrued on the scholarship notes which are paid back or bought out and interest on investments. The average maturity of RKMSF investments is just under 2½ years, with an average yield of 8.17%.

The Kentucky Medical Association continues to provide financial support to the RKMSF which greatly contributes to the success of the Fund. The RKMSF, while operated through the KMA, is a separate, nonprofit corporation, having its own officers and Board of Directors. This report is furnished as an informational item.

**Donald R. Stephens, MD**  
Chair

#### **Recommendations, Reference Committee 2:**

Reference Committee No. 2 reviewed the Report of the Rural Kentucky Medical Scholarship Fund. The Reference Committee was provided with additional information from Don Stephens, MD, and KMA staff, that showed this program to be highly successful and noted that many students have either gone to critical or rural counties or have decided to pay back their loans to the fund which have made the RKMSF self-sufficient. Reference Committee No. 2 recommends that the Report of the Rural Kentucky Medical Scholarship Fund be filed.

### **RESOLUTION K**

#### **Advance Directive Forms**

#### **Jefferson County Medical Society**

WHEREAS, Senate Bill 311, adopted by the 1994 Kentucky General Assembly, called for the Kentucky Board of Medical Licensure, in collaboration with the Cabinet for Human Resources, to develop a standard "Do Not Resuscitate" (DNR) form which would be recognized by any emergency medical responder; and



WHEREAS, a Kentucky Emergency Medical Services Do Not Resuscitate (DNR) Order has been devised and approved by the Kentucky Board of Medical Licensure and the Cabinet for Human Resources; and

WHEREAS, the DNR order form can be reproduced and has been forwarded to Kentucky Emergency Medical Services for distribution to the public upon request; now, therefore, be it

RESOLVED, that the KMA inform its members of the Kentucky Emergency Medical Services Do Not Resuscitate (DNR) Order form, and how it is intended to be used in order to minimize potential misunderstandings among physicians, EMS personnel, and affected family members throughout the state; and be it further

RESOLVED, that the KMA encourage its members to include the availability and use of the DNR Order form when they discuss advance directives with their patients; and be it further

RESOLVED, that KMA convey to associations representing hospitals, nursing homes, and emergency medical services the desire of Kentucky physicians that use of the DNR Order form be widely encouraged and honored.

#### Recommendations, Reference Committee 2:

The Reference Committee reviewed Resolution K, Advance Directive Forms, introduced by the Jefferson County Medical Society. The Reference Committee noted that this Resolution deals with Advance Directive Forms regarding "do not resuscitate" (DNR). The Reference Committee recommends that Resolution K be filed because the KMA is currently engaged in these activities and this is reaffirmation of existing policy.

## RESOLUTION M

### Socioeconomic Curricula for In-Training Physicians Young Physicians Section

WHEREAS, social and economic issues affecting the profession have a growing impact on the practice of medicine; and

WHEREAS, these issues most directly affect physicians on a daily business level; and

WHEREAS, most young or newly practicing physicians do not have the experience or training to adequately deal with many nonmedical aspects of the medical service delivery system and are hindered from devoting their whole attention to practice; and

WHEREAS, this disadvantage could be offset by formal exposure to the nonmedical aspects of medical practice in the training years; now, therefore, be it

RESOLVED, that KMA encourage the medical schools to include training in business topics in the curriculum of residents and students beginning with their clinical years.

#### Recommendations, Reference Committee 2:

The Reference Committee No. 2 next considered Resolution M, Socioeconomic Curricula for In-Training Physicians, submitted by the Young Physicians Section. The Reference Committee recommends that the Resolution be amended by deletion and substitution of the following Resolved:

RESOLVED, that KMA encourage the medical schools to include training in ~~business topics~~ **socioeconomic issues** in the ~~curriculum~~ **curricula** of residents and students. ~~beginning with their clinical years.~~

Mr Speaker, Reference Committee No. 2 recommends that Resolution M be adopted as amended.

## RESOLUTION Q

### Kentucky Organic Growers Estill County Medical Society

WHEREAS, in 1993 the Burley Tobacco Growers Cooperative Association established a pilot program, the Kentucky Organic Growers, which directly connected families with farm families by providing good food through employing sustainable agricultural practices; and

WHEREAS, in 1994 both the Kentucky Medical Association and the Kentucky Academy of Family Physicians adopted positions of support for the efforts of the Burley Tobacco Growers Association; and

WHEREAS, the Burley Tobacco Growers Cooperative Association plans to continue the efforts of the Kentucky Organic Growers and expand the opportunities for Kentucky's farmers to provide good, healthful food for Kentucky's families through the Commodity Growers Cooperative Association; and

WHEREAS, the medical community of Kentucky sees these efforts as vital to the health of Kentucky families; now, therefore, be it

RESOLVED, that the Kentucky Medical Association continue to show support for the Kentucky Organic Growers and the Commodity Growers Cooperative Association through educational efforts directed at patients and the community at large which emphasize the connection between agriculture and health; and be it further

RESOLVED, that KMA work with agricultural leadership, including the Burley Tobacco Growers Cooperative Association, to influence government policies which encourage local food production and allow good, healthful food to be available to all; and be it further

RESOLVED, that the KMA work with the Commodity Growers Cooperative in its efforts to fund the expansion of marketing opportunities for Kentucky farmers and to encourage the public to support sustainable agricultural traditions of local food production through consumption habits.

#### Recommendations, Reference Committee 2:

Reference Committee No. 2 reviewed Resolution Q and recommends its amendment by deletion of the three Resolveds and substitution of the following so that the Resolution, as amended, states:

RESOLVED, that the Kentucky Medical Association continue to show support for the Kentucky Organic Growers and the Commodity Growers Cooperative Association ~~through educational efforts directed at patients and the community at large which emphasize the connection between agriculture and health~~ **by educating patients and the community regarding the connection between health and agriculture**; and be it further

RESOLVED, ~~that KMA work with agricultural leadership, including the Burley Tobacco Growers Cooperative Association, to influence government policies which encourage local food production and allow good, healthful food to be available to all; and be it further~~

RESOLVED, that the KMA work with the Commodity Growers Cooperative Association in its efforts to fund the expansion of the marketing opportunities for Kentucky farmers and to encourage ~~the public to support/sustainable agricultural traditions of local food production through consumption~~ **the public to support/sustainable agricultural traditions of local food production through consumption** **and habits for the consumption of locally produced foods**; and be it further

RESOLVED, that the KMA communicate, again, to the Board of the Commodity Growers Cooperative Association and its parent organization (Burley Tobacco Growers Association) its support for these progressive efforts.

Mr Speaker, Reference Committee No. 2 recommends that Resolution Q be adopted as amended.

The motion was seconded and carried.

Resolution Q, adopted as amended, reads as follows:

## RESOLUTION Q

### (Adopted as amended)

### Kentucky Organic Growers Estill County Medical Society

WHEREAS, in 1993 the Burley Tobacco Growers Cooperative Association established a pilot program, the Kentucky Organic Growers, which directly connected families with farm families by providing good food through employing sustainable agricultural practices; and

WHEREAS, in 1994 both the Kentucky Medical Association and the Kentucky Academy of Family Physicians adopted positions of support for the efforts of the Burley Tobacco Growers Association; and

WHEREAS, the Burley Tobacco Growers Cooperative Association plans to continue the efforts of the Kentucky Organic Growers and expand the opportunities for Kentucky's farmers to provide good, healthful food for Kentucky's families through the Commodity Growers Cooperative Association; and

WHEREAS, the medical community of Kentucky sees these efforts as vital to the health of Kentucky families; now, therefore, be it





RESOLVED, that the Kentucky Medical Association continue to show support for the Kentucky Organic Growers and the Commodity Growers Cooperative Association by educating patients and the community regarding the connection between health and agriculture; and be it further

RESOLVED, that the KMA work with the Commodity Growers Cooperative Association in its efforts to fund the expansion of marketing opportunities for Kentucky farmers and to encourage public support for the consumption of locally produced foods; and be it further

RESOLVED, that the KMA communicate, again, to the Board of the Commodity Growers Cooperative Association and its parent organization (Burley Tobacco Growers Association) its support for these progressive efforts.

## RESOLUTION R

### Optometrists as Primary Care Providers Fayette County Medical Society

WHEREAS, the Kentucky Medical Association is concerned about the general health and well-being of the citizens of Kentucky; and

WHEREAS, primary care providers should be physicians; and

WHEREAS, optometrists have not had the benefit of medical education or postgraduate training; now, therefore, be it

RESOLVED, that the Kentucky Medical Association opposes any legislation allowing optometrists to provide, act, or serve as primary care providers in performance of the practice of medicine, surgery, or laser surgery in the Commonwealth of Kentucky.

### Recommendations, Reference Committee 2:

Reference Committee No. 2 reviewed Resolution R and recommends amendment of the Resolved by deletion of the words "any" and "provide" and to delete the phrase, "surgery, or laser surgery." As amended the Resolution would state:

RESOLVED, that the Kentucky Medical Association opposes ~~any~~ legislation allowing optometrists to ~~provide~~, act, or serve as primary care providers in performance of the practice of medicine, ~~surgery, or laser surgery~~ in the Commonwealth of Kentucky.

Mr Speaker, Reference Committee No. 2 recommends adoption of Resolution R as amended.

A motion was made from the floor to reinsert the text "surgery, or laser surgery" stricken by the reference committee. After some discussion, the motion was seconded and carried.

The amended Resolved, as adopted, reads as follows:

**RESOLVED, that the Kentucky Medical Association opposes legislation allowing optometrists to act or serve as primary care providers in performance of the practice of medicine, surgery, or laser surgery in the Commonwealth of Kentucky.**

Mr Speaker, Reference Committee No. 2 recommends the adoption of the report of Reference Committee No. 2 as a whole, as amended.

Mr Speaker, I would like to thank the other members of the Committee: John S. Cave, MD, Henderson; Frank B. Miller, MD, Louisville; Barbara A. Phillips, MD, Lexington; William D. Pratt, MD, London; and Thomas K. Slabaugh, MD, Lexington. I also want to personally thank Denise Scinta for her assistance in the preparation of this report.

Respectfully submitted,  
REFERENCE COMMITTEE NO. 2  
Baretta R. Casey, MD, Pikeville, Chair  
John S. Cave, MD, Henderson  
Frank B. Miller, MD, Louisville  
Barbara A. Phillips, MD, Lexington  
William D. Pratt, MD, London  
Thomas K. Slabaugh, MD, Lexington

**Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.**

## REPORT OF REFERENCE COMMITTEE NO. 3

### Thomas E. Bunnell, MD, Erlanger, Chair

22. Report of the Maternal Mortality Study Committee
23. Report of the Committee on National Legislative Activities
24. Report of the Committee on State Legislative Activities
25. Report of the Committee on Professional Liability Insurance
26. Report of the Committee on Care for the Elderly
27. Report of the Public Education Committee
- Resolution E — Youth Access to Tobacco Products  
(Fayette County Medical Society)
- Resolution I — Reaffirming Provider Tax Opposition  
(Jefferson County Medical Society)
- Resolution J — Provision for Decision to Withhold Futile Medical Intervention by State-Appointed Guardianship Services  
(Jefferson County Medical Society)
- Resolution N — Provider Tax  
(Warren County Medical Society)
- Resolution O — Robert Wood Johnson Foundation's Interference in Kentucky State Government  
(Warren County Medical Society)

### ITEMS FOR CONSENT

Reference Committee No. 3 reviewed the following items and recommends they be filed, by consent of the House, without discussion:

22. Report of the Maternal Mortality Study Committee — filed
23. Report of the Committee on National Legislative Activities — filed
25. Report of the Committee on Professional Liability Insurance — filed
26. Report of the Committee on Care for the Elderly — filed
27. Report of the Public Education Committee — filed

Mr Speaker, Reference Committee No. 3 recommends the adoption of the Consent Calendar as a whole.

## Report of the Maternal Mortality Study Committee

The Maternal Mortality Study Committee of the Kentucky Medical Association met once during the organizational year — September 20, 1994. Only seven cases were available for study. Considerable detailed discussion took place among the committee members about these. After extensive review, the following classifications were made.

### MATERNAL MORTALITY STUDY TABLE

Obstetric Indirect	Questionable preventable — overwhelming sepsis post Cesarean due to Herpes Simplex Hepatitis Earlier treatment <i>might</i> have influenced outcome Autopsy was done to confirm above
Obstetric Indirect	Dissecting descending aneurysm Possible preventable factor — patient refused admission to hospital for treatment of hypertension Autopsy was done to confirm above
Obstetric Direct	Bleeding following difficult twin delivery Possible preventable factors — failure to give adequate blood replacement and diagnose cause of bleeding A consumptive disseminated coagulopathy was diagnosed. Question of amniotic fluid embolism No autopsy was done
Obstetric Direct	Nonpreventable Amniotic fluid embolism during labor Diagnosis confirmed by autopsy
Obstetric Indirect	Obstetric — nonpreventable subarachnoid hemorrhage by CT scan
Obstetric Indirect	Nonpreventable Died 6 days after a Cesarean birth for face presentation Autopsy showed no anatomic cause of death —

negative toxicology. Patient was on Bromocriptine for suppression of lactation  
 Obstetric Indirect Questionable preventable  
 Motor vehicle accident — extensive skull fractures and brain laceration

It is gratifying that only one or two of these cases were felt to have preventable factors. Cases have been submitted to the *Journal of the Kentucky Medical Association*.

We are indebted to the diligent efforts of Dr John Petry for his significant contribution in finding and preparing cases for the Study Committee.

**John W. Greene, Jr, MD**  
 Chair

## Report of the Committee on National Legislative Activities

The priority in national medical legislation this year was toward reform, and the Committee on National Legislative Activities followed developments in this area very closely. The depth and breadth of activities that organized medicine marshaled to address this issue were unparalleled. The intensity of effort from the level of the individual physician to the combined energy of all medical societies and associations in the country was directed to this issue.

Tort reform began in the US House of Representatives as HR 10, the Legal Reform Act. This was subsequently divided into three separate bills — HR 1058, the Securities Litigation Reform Act; HR 956, the Product Liability and Legal Reform Act; and HR 988, the Attorney Accountability Act. Regardless of the subdivision of issues, it was the intent and the ultimate result of Congress to accomplish product liability reform.

Organized medicine saw the opportunity to effect medical tort reform, ultimately succeeded in attaching medical provisions to the product liability debate, and an unprecedented success occurred in the House. HR 956 successfully passed the House and contained the following provisions: the establishment of federal courts as a venue for tort liability cases, a cap on economic damages of \$250,000 or three times the amount of punitive damage if flagrant indifference could be demonstrated, a limit of \$250,000 for noneconomic damages in medical liability cases, prohibition of any recovery if alcohol or drugs could be proven to be involved on the part of the plaintiff, joint or several liability, and a statute of limitations of 15 years for product cases.

In the Senate, the sessions became focused and contained in S 565, which was primarily a product liability bill. The key item for medicine in the Senate was, again, a limit on noneconomic damage awards of \$250,000. In spite of intense and even zealous efforts on the part of organized medicine, the medical liability aspect of the bill was ultimately deleted. Most of the other provisions relating to product liability from the house bill were retained.

As of this writing, the bill has not yet been assigned to a conference committee to resolve House and Senate differences, the most obvious contradiction being the medical liability provision. When the bill is assigned to a conference committee, medicine will again mount its most intensive effort to include the medical liability provisions, although the current climate indicates that it is not likely this effort will be successful.

The American public instituted a new mood in Congress by electing a majority of Republicans in both houses. It is likely that this mood of political reform will be carried on by medicine in view of the Senate vote on medical liability concerns and the probable exclusion of them from the future conference committee bill. This mood will lay the basis for future political alignments in Congress. Hopefully, this will engender a strengthened medical constituency with a stronger voice and more effective influence.

A sequential priority for national legislation will be Medicare reform or Medicare changes. Both congressional parties and the administration have committed to balanced budget efforts, and there seems to be a tacit understanding that Medicare will be a focus of those efforts. The question does not seem to be **if** Medicare expenditures will be targeted for reduction, but **when** and to what degree.

Rather than continue the piecemeal revisions of Medicare that have characterized budget consideration efforts in the past, the AMA has taken

a strong prospective position and has suggested to the Congress some significant Medicare program transformations. Extensive AMA evaluation and development have resulted in a comprehensive plan that will involve patients, physicians, and government to reduce the expected growth of Medicare over time, yet continue to provide appropriate benefits to current and future generations.

In summary, the AMA plan has five essential provisions. These are:

1. Greater beneficiary involvement in financing consciousness;
2. Provisions to promote price competition among physicians and providers to increase economic efficiency;
3. A change in the financial participation by different generations, which may include means testing;
4. The establishment of long-term programs for the current working generation to reduce future dependence on Medicare;
5. A reduction in the regulatory and administrative complexity of the program.

The AMA plan is comprehensive, rational, and far-ranging. If America is to avoid the inadequacy of previous short-term, quick-fix solutions to the Medicare program problem, the AMA plan or one containing many similar elements must be adopted.

In the regulatory area, efforts this year have been undertaken to modify and repeal the Clinical Laboratory Improvement Act of 1988; to repeal the National Practitioner Data Bank statute; to modify the current and recently enacted self-referral laws; to streamline OSHA regulations on blood-borne pathogens relative to cost benefit; and to work toward clear regulations and enforcement standards relating to the Americans with Disabilities Act which would require medical practice modification.

In the coming year social demands for medical care will continue to be tempered by fiscal realities and greater public focus and influence on these changes will result. Our involvement in shaping these changes was never more critical.

**Donald C. Barton, MD**  
 Chair

## Report of the Committee on Professional Liability Insurance

The Committee on Professional Liability Insurance met on one occasion during the 1994-95 Associational year. The committee was extremely involved in the federation lobbying effort led by the AMA to limit awards for noneconomic damages in malpractice cases to \$250,000. The PLI Committee contributed \$5,000 to support AMA's advertising campaign to build support for the amendment to the product liability legislation. A full report of this tremendous effort by AMA is included in the Delegates to AMA Report. Although the effort failed, we believe momentum is building throughout the public sector for tort reform. In addition to the contribution, we also sent a letter to every Kentucky physician with instructions on contacting their US Senator. We also implemented the KMA/KMAA phone bank to promote the effort.

In addition to the efforts on the national level, we intend to continue with our proposed Kentucky constitutional amendment to limit noneconomic damages in malpractice cases. While we face an uphill battle, we will continue our struggle which, in essence, is all people's struggle to correct a legal system out of balance and which no longer serves the public. We need every physician to visit with their legislators and educate them on the cost of defensive medicine and the tremendous toll it takes on our medical delivery system.

**Wally O. Montgomery, MD**  
 Chair

## Report of the Committee on Care of the Elderly

The Committee on Care of the Elderly has had a year of gratifying accomplishment in pursuit of its mission to provide a forum for clinicians to discuss geriatric care issues, to effect liaison with associated elderly representative groups, and to act as an advocate on behalf of clinicians.





During the year, the committee received information from the KMA staff on various legislative issues, which included reimbursement cuts under the Medicaid program, KMA's legal challenge to those cuts, fraud and abuse provisions of HB 250, the supposed Discount Option Program, efforts to repeal the provider tax, and DNR legislation.

As part of its annual effort to provide a forum for discussion of topics pertinent to clinicians and elderly representative groups, the committee developed a forum on aging, with the primary topic being "End of Life Issues." This forum, which was ultimately titled "Decisions at the Conclusion of Life," was held on Wednesday, May 10, at the Holiday Inn on Hurstbourne Lane in Louisville. Attendees were by invitation only, and were members of organizations which deal with the aging and their problems. Approximately 40 attendees were present for an excellent series of presentations and discussion on end-of-life problems.

Faculty members included Rabbi Samuel Mann of Louisville, who spoke on "Changing Approaches to End-of-Life Issues in the Jewish Tradition"; Dwight L. Blackburn, MD, of Southeastern Group, who spoke on "Economic Realities and Dilemmas of End-of-Life Decisions"; James L. Bean, MD, who chaired KMA's Ad Hoc Committee on DNR, who spoke on "Medical Components of Life Conclusion Determinants"; the Reverend Ronald M. Kettler of Northern Kentucky, representing the Catholic Conference, who spoke on the "Theological Perspectives on Life Conclusion in the Social Context"; and the Honorable David K. Karem of the Kentucky State Senate, who spoke on "An Appraisal of Legal and Legislative Dynamics Related to End of Life." A brisk, stimulating, and productive panel discussion and question and answer session followed.

This meeting resulted in both a scholarly and practical examination of this significant topic, which expanded the understanding — and questions — of all participants.

The committee also considered Resolution L, this year, which was referred by the Board of Trustees. Resolution L, adopted by the House of Delegates last September, called on KMA to investigate regulations imposed on nursing homes and home health agencies that have a negative influence on patient care merit, intrude into providers' time, and might unnecessarily increase costs. This investigation proved to be a daunting task, because no specific area of practice or care process could be singled out to identify onerous regulations. Rather, negative regulatory impact affected many parts of the care process. These negative dynamics ranged from the requirement for physicians to fill out multiple-page durable medical equipment requests, to automatic disallowance of physician-prescribed psychotropic drugs for nursing home patients as part of nursing home facility inspection regulations.

One of the committee members, Dr Harold Haller, has conducted considerable work in reviewing various aspects of medical practice and regulatory interaction. Although a thorough review of all regulations is quite formidable, the committee will continue its efforts and make recommendations to the Board of Trustees on its findings for further action.

I would like to express my deep appreciation for the efforts of all the committee members for their contributions and work toward our mutual efforts this year.

**S. Philip Greiver, MD  
Chair**

## Report of the Public Education Committee

The KMA Public Education Committee met on four occasions following the completion of the written final report to the 1994 House of Delegates. In keeping with the committee's charge, we have concentrated our efforts in the following areas:

- Quarterly patient newsletter
- Audio news
- Speakers bureau/slide presentations
- General PR programs, activities, and responses
- Educating patients, staff, and physicians on the damaging aspects of HB 250 on access, quality, and cost of medical care.

The Public Education Committee has been charged with developing and initiating a public education campaign to inform patients, physicians, the general public, as well as other persons who influence health care in

Kentucky, regarding positive aspects of the role physicians play in service to the people of the Commonwealth.

Our primary project and the flagship of the committee's effort to fulfill the KMA House of Delegates directives is the patient newsletter *MediScope*. The first issue was mailed prior to the 1994 KMA Annual Meeting. Future issues of *MediScope* will be published in January, April, August, and October and will include a form for ordering additional copies. The cost for additional copies of *MediScope* is \$15 per hundred, plus postage. *MediScope* is an invaluable addition to physicians' practices and we encourage every physician to make copies available to their patients. The Fall 1994 issue of *MediScope* and future issues will be mailed to Kentucky's legislators and hospitals. Requests from individuals to receive a single copy of *MediScope* are being honored at this time. We are seeking suggestions to increase distribution to patients. An informal survey may be conducted to determine if the newsletters are being used extensively in waiting rooms.

Our PR consultant noted that KMA could obtain approximately \$100,000 worth of advertising for around \$25,000 a year by converting *MediScope* into the form of a 60-second radio commercial. He suggested that we try it for one quarter. The committee authorized approaching the Broadcasters Association for additional information on the cost of airing *MediScope* in commercial form.

We continue to utilize audio news tapes to get our message out to the public. The committee has approved the production of the following audio tapes to be distributed to all Kentucky radio stations:

- Sunburn
- Sports Injuries
- Dehydration
- AMA Patient Protection Act

We will continue to work in this area and define topics that are seasonal and timely and promote the physician/patient relationship.

The committee has a presentation on AIDS on file in the KMA office and available to members. In addition, we have available a presentation on smokeless tobacco. Future issues of the patient newsletter will contain notice of the availability of these presentations. National, state, and specialty societies have been contacted regarding the availability of similar presentations. They have responded by providing us with five video presentations. We have made several efforts to obtain a presentation on "How to Become a Doctor" and will continue to work with medical schools in an attempt to develop a presentation that might be utilized by members for events such as "Career Day," etc.

The committee continues to search for new ideas and programs relevant to our charge. We are trying to improve our communication effort and work with the news media in a more organized and systematic way. We are mailing periodic press releases relating to specific monthly *Journal* articles and responding to the media via guest editorials and op-ed pieces.

Upon request by the Jefferson County Medical Society, the committee agreed to cosponsor a seminar entitled "Under the Microscope: The Relationship Between Physicians and the News Media." The seminar will feature Harrison L. Rogers, Jr, MD, Past President of AMA; Rita Rubin, Associate Editor of *US News and World Report*; Michael Gartner, former President of NBC News; and David V. Hawpe, Editor of the *Courier-Journal*. The committee is optimistic that this seminar will foster a clearer understanding between the two groups and enhance local relationships.

An AMA program designed to increase interest in medicine as a career which involves women physicians and Girl Scouts, entitled "The Physicians of Tomorrow Mentoring Program," was approved and recommended to members of KMA. The program was summarized in the *Communicator*.

In 1994 the committee authorized a grant to the Kentucky Medical Association Alliance for public education programs. The following criteria were adopted as guidelines for granting funds to KMAA to establish a statewide public education program:

1. Proposed projects should be related to public education, enhancement of the patient/physician relationship, or designed to improve the public image of physicians and the profession.
2. A written request should include the following:
  - a. Purpose
  - b. Plan of action
  - c. Objectives
  - d. Budget
3. Projects should be managed by the KMAA Board or designated commit-



tee, have statewide implications, and be adaptable for use on the county Alliance level.

4. Following completion of the project, the President of the Alliance or designated Chair should provide a summary of the project to the Public Education Committee.

Joyce Clark, KMAA President, presented several recommendations to the committee in response to the committee's offer of a grant. Programs suggested for consideration include a breast cancer awareness program, an antismoking program in schools, and a "Stop the Violence" program.

The committee was quite impressed with all of the projects and has asked the Alliance to determine which project they would like to carry out and the committee will fund the program.

The committee received two referrals from the 1994 House of Delegates: **Resolution A — Provider Tax.** William B. Monnig, MD, addressed the committee regarding implementation of Resolution A. The committee voted to develop packets to assist physicians in writing a letter to legislators who voted for the provider tax, a letter to legislators who voted against the provider tax, and a letter for patients to mail to their legislators opposing the tax. The committee also approved the printing of bumper stickers stating, "Repeal the Tax."

Each KMA member will receive two legislative packets prior to the 1996 Kentucky General Assembly. One packet will be mailed in June and the other in the fall of 1995. The packet will include the following:

1. Cover letter from the committee chair
2. Two booklets (*Facts & Fables* and KMA's Legislative Handbook)
3. Legislators voting record
4. A response card
5. Activities schedule
6. A "Repeal the Tax" bumper sticker
7. Credit card-size card with provider tax and Medicaid data

The booklet entitled *Facts & Fables* will be included in physician and legislator packets. This booklet contains facts and figures relating to the Medicaid program and physician reimbursement in Kentucky. We also developed an enclosure for the packets which will list every legislator's name in the 1994 General Assembly and how they voted on HB 250. We have printed 11,000 copies of *Facts & Fables* for distribution to members, legislators, and health writers for the major Kentucky newspapers. The importance of getting this information into the hands of physicians and subsequently to legislators is of paramount importance. The packet will also be distributed to delegates at the Annual Meeting and be available at the Public Education Committee booth at the Annual Meeting.

**Resolution M — Practice Environment in Kentucky.** This resolution concerned the effects of the provider tax, Medicaid cuts, and punitive features of HB 250. The committee printed information in *MediScope* regarding the punitive practice environment in Kentucky and its effect on access to health care.

One of the most difficult tasks for members of the Public Education Committee is patience. Members of the committee truly want to do a good job and want to achieve our stated goals. We were cautioned from the beginning that our job would not be easy and that it would take years to accomplish the goals we established for ourselves. We face an increasingly hostile press and media who believe the ills of society can be traced to physicians and can only be solved by physicians.

After discussing these problems and issues, the committee explored the possibility of conducting a rather extensive but budget-limiting statewide PR program. We hired an outside consultant to frame the issues, design a program, project the costs, and schedule the program for the latter part of 1995 and through the 1996 Kentucky General Assembly.

Our special consultant presented a proposal to the committee for an advertising blitz consisting of billboard advertising, newspaper, radio and TV advertising, and a TV infomercial or docuserial. The cost of such a program would range from \$75,000 to \$100,000. After considerable discussion of budget needs and the fact that such a program would require placing our ongoing projects on hold, the committee recommended that a statewide advertising campaign not be undertaken at this time. In addition, we were troubled with some phases of the proposal. It would have required us to aggressively attack powerful political forces in the public arena. We were reluctant to take this step believing that the long-term effect of patients' perceptions of the profession and Association would be irreversibly altered. We found the proposal incompatible with medicine and KMA's traditional

professional image and the future of the physician/patient relationship.

Recognizing that the 1996 session of the Kentucky General Assembly will be extremely difficult, the committee recommended and agreed to fund pre-legislative conferences in each of KMA's 15 Trustee Districts. The Board of Trustees approved the programs at its April meeting. Conferences will begin in early October and conclude no later than November 15, 1995. Conference invitees include physicians, spouses, and other interested parties supportive of our efforts. Dates, locations, and times of meetings will be coordinated with the KMA District Trustee and the Public Education Committee will present its plans and activities leading up to and including the 1996 Kentucky General Assembly. We plan a very exciting program that will be informative and interesting. Topics will include repeal of the physician component of the provider tax, tort reform, amending sections of HB 250, reforming Medicaid, growth of managed care, continued inroads by nonphysician practitioners, and other legislative concerns and issues identified as important to the medical profession and its patients. Political activity will also be highlighted including the restructuring of KEMPAC and its future goals. In addition, providing KMA legislative key contacts with additional information and lobbying techniques will be an important function of these conferences. Discussions on establishing local phone banks, use of local mailings, etc., will be an agenda item at these conferences.

Speakers will include KMA officers, trustees, Public Education Committee members, Alliance representatives, KEMPAC officers, and lobbying staff. A packet defining the issues will be handed out to each attendee at the conference. In addition, material to assist in the lobbying effort will be included along with recommended visitation plans with individual legislators at both the local level and visitations to Frankfort. We urge every physician and spouse to plan to attend these conferences.

Obviously, the committee has worked extremely hard to meet its established goals. We recognize the need to be patient and understanding and will continue to develop and fund only those programs which send the appropriate impression of medicine and over the long haul contribute to the physician/patient relationship.

On behalf of the members of the committee we appreciate the support provided us. We especially recognize the talents of our consultant, Mr Glen Bastin. Glen has become a true asset to our committee and this Association and has added immeasurably to our efforts to educate the public.

**Preston P. Nunnelley, MD**  
Chair

## END OF CONSENT CALENDAR ITEMS

### Report of the Committee on State Legislative Activities

The Committee on State Legislative Activities met on two occasions in the 1994-95 year. Several referrals from the House of Delegates were considered and acted upon.

The committee's first task was to tackle the very difficult Resolution N — Shortage of Long Term Beds — which was adopted by the House with little discussion in 1993. Resolution N directed the legislative committee to resolve the long term bed shortage and devise a "master plan" to address this issue in the 1990s. However, due to the pressure of health care reform we delayed action. Ms Donna Brown, Legislative Affairs Director for Kentucky Association of Health Care Facilities (KAHCF), was invited to address the committee at its December 1994 meeting regarding the need for additional long term beds. She explained that the state budget now determines the number of beds and House Bill 1 (the current state budget) states that no new beds will be built without the explicit approval of the General Assembly. She submitted KAHCF's recommendations for increasing the number of long-term care beds:

1. Personal Care (PC) upward conversion to Nursing Facility (NF or ICF/ Skilled) in a licensed nursing facility with more than one level of care. (Example: A nursing home currently has 50 NF beds and 10 PC beds. Allow the 10 PC beds to become NF beds. The entire facility is probably already built to code for NF; no physical plant changes will have to be made; only increased staff will be needed to offer the higher level of care to the additional 10 beds.)
2. The Cabinet for Human Resources can complete and submit an applica-





tion for approval of a federal Medicaid waiver allowing existing providers with freestanding personal care beds (those for which it would be economically feasible) to convert those beds to Intermediate Care (ICF) level of care. This would involve additional training of nurses aides, increased staffing, and in some cases, some physical plant upgrades. There are approximately 7,400 licensed personal care beds in Kentucky. An estimated 3,700 are freestanding with the remainder in multilevel facilities.

3. Biennial bed growth of 10 beds or 10% (whichever is fewer) to an existing nursing facility to be CON-exempt, so long as the nursing facility had a minimum occupancy rate of 96% during its most recent 12-month cost reporting period.
4. KAHCF supports expansion of community-based services. These services care for a completely separate population from nursing homes, yet nursing homes could easily offer these home-based services with the best economies of scale. With nursing homes and trained professional staff in virtually every county in the state, they offer a solid history of service and employment in the community; a pool of trained professional staff; meals prepared daily; and most nursing homes already have contracts with other professionals, such as physical therapists, occupational therapists, dentists, etc., that can also be offered through the community-based services.
5. As patients are frequently discharged sooner from the hospital, nursing homes should be recognized as capable of caring for the so-called "sub-acute" patients. Nursing homes can provide enhanced quality of care at a substantial cost saving to Medicaid, Medicare, and private payers. They now offer specialized skilled care for advanced rehabilitation, heavy IV use, ventilator care, head trauma, and wound care.

The KAHCF made the following recommendations to physicians for encouraging more long-term beds:

1. Communicate with the Health Policy Board (HPB).
2. Call legislators and leave a message that your patients cannot find a nursing home bed; that the state needs more long-term care beds.
3. Have patients' families call legislators and advise them of the bed shortage. The committee agreed to study these recommendations.

At a follow-up meeting in April, the committee carefully reviewed Ms Brown's recommendations but could not fully support KAHCF's position. In light of the controversy surrounding HB 250, the provider tax, and Medicaid reimbursement cuts, the committee is reluctant to address the nursing home bed shortage in the 1996 legislative session. House Bill (HB) 250 has had additional impact upon bed availability since the General Assembly placed Certificate of Need under the control of the Health Policy Board. Contact was made with the HPB in an attempt to obtain information on CON and the status of extended care beds in the Commonwealth.

The HPB is revising the State Health Plan (SHP), which provides a general overview of health care in Kentucky and is the primary document articulating health policy in the state. The SHP establishes the criteria to be used in CON reviews. The committee recognizes that this is an extremely complex issue and that further expansion of beds has a huge financial impact upon the state's Medicaid budget. Additional funds are simply not available and payment for expansion and use of beds would come from other designated provider funds. One of our major legislative agenda items is to repeal the provider tax. Recognizing this concern and caution, the following recommendation was adopted:

The Committee on State Legislative Activities recommends that KMA urge the Kentucky General Assembly to appoint a task force to study the issue of the limited supply of extended care beds in Kentucky.

If this recommendation is adopted by the House of Delegates the KMA will seek sponsors for such a resolution. The committee regrets that it is unable to devise a solution or master plan to the dilemma in which society finds itself. A shrinking federal budget with block grants to states will create enormous political problems for state government as it attempts to balance the need for medical services for the young and exploited versus the tremendous clout of the elderly population. The elderly continue to resist changes in the present format of health care delivery. As Chairman, I recommend that nursing bed shortages remain the responsibility of society as a whole and particularly state government. KMA's limited resources and political power must be focused on those issues where we can truly have an impact. However, we will continue to review nursing bed shortages and, as we have previously, support reasonable expansion where fiscally appropriate.

Resolution A — Provider Tax, Reference Committee Substitute Resolution in Lieu of Resolution F — HB 250, and Resolution G — Copying Patient Records, were referred to this committee. As of June 1995 three to four pre-filed bills call for repeal of the provider tax. In addition, two bills call for repeal of the requirement to provide medical records and limit copying charges. We are optimistic that some relief will be forthcoming from the punitive sections of HB 250, including the provider tax, Discount Option Program (DOP), and copying medical records.

The committee established the following 1996 legislative goals:

1. Tort Reform — KMA support a constitutional amendment that would permit the General Assembly to place a limit on noneconomic awards.
2. Repeal the 2% provider tax on physicians' gross incomes.
3. Restoration of reasonable Medicaid reimbursement rates to physicians.
4. Repeal or amend HB 250 including the DOP, practice parameters, medical records, etc.
5. Oppose inappropriate legislation which expands the scope of duties of nonphysician practitioners through legislative fiat.

In several states, optometrists are seeking expansion of their practice into the surgical arena. In relation to this situation the committee adopted the following recommendation:

The Committee on State Legislative Activities recommends that the use of laser equipment in surgery be defined as the practice of medicine in any legislative bill introduced in the Kentucky General Assembly by KMA with regard to health care reform.

At its December meeting, the committee reviewed a proposal by the Physician Assistant Advisory Committee to the Kentucky Board of Medical Licensure (KBML). The Advisory Committee had recommended that KBML, by regulation, license physician assistants (PAs) and grant prescriptive authority. This committee reaffirmed the long-standing position of the KMA House of Delegates which opposes licensure of nonphysician practitioners and that only the General Assembly has the power to grant prescriptive authority. A motion was adopted recommending that KMA oppose the proposed changes in physician assistant regulations presented to the Committee on State Legislative Activities both in the General Assembly and to the Kentucky Board of Medical Licensure.

This controversy was intensified by the Secretary of CHR placing a moratorium on payment for PA services based on the premise that PAs are certified rather than licensed. This subsequently created concern and the committee was asked to reconsider the issue at a follow-up meeting. Following careful review, the committee again reaffirmed House of Delegates policy and recommended that KMA respond to the inquiry from the Kentucky Board of Medical Licensure (KBML) by stating that, due to KMA and AMA policy, KMA cannot support changing the certification of physician assistants to licensure. Further, KMA continues to support the use of physician assistants in medical practice and appropriate reimbursement for PA services. The committee also recommends that KMA urge the Secretary of CHR to reconsider his decision not to reimburse PAs for services rendered to Medicaid patients and seek resolution to this problem. With the growth of the PA program at the University of Kentucky and recommendations to expand the number of PAs in HB 250, particularly in rural and inner city areas, incentives for practicing physicians to employ PAs will cease to exist.

While the House of Delegates has endorsed the use of PAs and ARNPs, some caution is indicated and I feel compelled to sound a warning. Despite all the protestations you hear, in all probability PAs and ARNPs will eventually seek equal footing with physicians. We have fought this battle year after year, whether it be optometrists, physical therapists, or ARNPs, all practitioners are single-minded in their pursuit of independence. The planned increase in the number of PAs and ARNPs will make them powerful adversaries of primary care physicians competing for patients.

The KBML also requested that KMA review a draft of "Guidelines for Prescribing of Controlled Substances" which were written at the request of the Board as an educational tool for physicians. The KMA Executive Committee referred the guidelines to COSLA for review and comment. The committee noted that it shares the concerns of KBML with the issue of prescription of controlled substances and recommends that the KMA Board of Trustees appoint an ad hoc committee to study the "Guidelines for Prescription of Controlled Substances," prepared by L. Douglas Kennedy, MD, and provide recommendations on this issue to KBML.

As directed, the committee's recommendations relating to physician assistant licensure and prescriptive authority, along with recommendations



regarding prescription of controlled substances, were referred back to the KMA Executive Committee which met in July and at the August Board of Trustees meeting. The House of Delegates will be informed of the KMA Board's response to the Kentucky Board of Medical Licensure.

**Resolution R — Use of Laser Therapy.** The Insurance Commissioner and insurance companies have been notified of the adoption of Resolution R. The resolution called for ophthalmologists to be regarded as comprehensive (primary, secondary, and tertiary) eye care providers.

**Resolution S — Use of Laser Therapy.** It was noted that this resolution was adopted and referred to the Committee on State Legislative Activities for future policy direction. Resolution S resolved that laser procedures are invasive and that only physicians should be authorized to utilize laser therapy.

To assist members of KMA, the following plans have been made for the 1996 legislative session:

- A pocket-sized legislative handbook will be prepared and mailed to members.
- Background information on the legislative session will be included in the January 1996 issue of the *Journal*.
- KMA is establishing a "fax network." All KMA members are being urged to submit fax numbers to the headquarters office for use in the 1996 session.
- A "Legislative Seminar" will be held in Frankfort in late January or early February 1996.

The Public Education Committee has agreed to support COSLA's efforts in the following manner:

- Information packets will be mailed to all KMA members to assist them in discussing legislative issues with their local legislators. Included in the packet will be a list of all legislators and their voting record on House Bill 250, and a pocket card (similar to a credit card) listing helpful information for members to use regarding HB 250. In addition, supportive information on Medicaid, tort reform, HB 250, and other issues will be included.
- Pre-legislative conferences are being planned for the fall of 1995 and will be held in each of KMA's 15 Trustee Districts. These conferences will be sponsored by the Public Education Committee to prepare physicians and spouses for the 1996 session of the Kentucky General Assembly.

During the session, weekly legislative updates will be mailed to KMA members, Alliance members, and KMGMA (Kentucky Medical Group Management Association) members.

The political climate has certainly grown more conservative when compared to the dark days of the 1994 session. The Kentucky Senate now has 17 Republican members and 21 Democrats so that ought to slow down the train. On the House side, we have 37 Republicans and 63 Democrats. In 1994 there were only 29 Republicans. While you might question the relevance of three more Republican Senators and eight more Republican House members — remember that in 1994 House Bill 250 was adopted 21-17 (only 14 Republican Senators) and 56-43 in the House (only 29 Republicans). Under the present scenario it is unlikely that "social reconstruction" type legislation similar to KERA or HB 250 could be adopted.

Someone recently remarked that political involvement and the financial support of candidates ought to be part of physicians' continuing medical education requirements. I hope every member has gotten involved in the gubernatorial campaign and is working both financially and personally for the candidate of choice. The Governor, despite the General Assembly's grasp for power, still has enormous political clout. With 100 of 100 House members and 19 of 38 Senate members facing the electorate 40 days after the adjournment of the 1996 session, coupled with the threat of a Republican majority in the Senate and House, the General Assembly should be more cautious and responsible in addressing issues such as health care.

Thank you again for your encouragement and we look forward to working with each of you in 1996.

**Wally O. Montgomery, MD**  
Chair

## RECOMMENDATIONS:

1. The Committee on State Legislative Activities recommends that KMA urge the Kentucky General Assembly to appoint a task force to study the issue of the limited supply of extended care beds in Kentucky.
2. The Committee on State Legislative Activities recommends that the use of laser equipment in surgery be defined as the practice of medicine in

any legislative bill introduced in the Kentucky General Assembly by KMA with regard to health care reform.

## Recommendations, Reference Committee 3:

Reference Committee No. 3 reviewed the Report of the Committee on State Legislative Activities and its two Recommendations concerning the appointment by the Kentucky General Assembly of a task force to study the issue of limited supply of extended care beds in Kentucky and the use of laser equipment in surgery to be defined as the practice of medicine in any legislative bill introduced in the Kentucky General Assembly. Reference Committee No. 3 recommends the adoption of Report No. 24 and both of these recommendations.

## RESOLUTION I

### Reaffirming Provider Tax Opposition Jefferson County Medical Society

WHEREAS, the KMA House of Delegates at the 1994 Annual Meeting adopted the Board of Trustees' Amended Resolution A, which resolved, in part, that "KMA develop and disseminate a legislative strategy to improve the likelihood that the 1996 Legislature will rescind the so-called provider tax, or 'sick' tax, as a method of funding the Medicaid budget"; and

WHEREAS, ultimate decision to repeal the provider tax will rest with legislators who typically demand to know how the provider tax funds would be replaced; now, therefore, be it

RESOLVED, that the KMA reaffirm its opposition to the provider tax; and be it further

RESOLVED, that the KMA maintain as a top legislative priority the repeal of the provider tax by the 1996 Kentucky General Assembly; and be it further

RESOLVED, that the Committee on State Legislative Activities be prepared to propose, and if deemed advisable, to publicly promote, a fair and reasonable alternative to the provider tax that would provide funding in a manner which reflects the broad public interest that the Medicaid program serves across all strata of Kentucky's population.

## Recommendations, Reference Committee 3:

Reference Committee No. 3 reviewed Resolution I, Reaffirming Provider Tax Opposition, submitted by the Jefferson County Medical Society. The Committee recommends that the third Resolved be deleted and that Resolution I be adopted as amended.

The motion was seconded from the floor and carried. The Resolved section of Resolution I reads as follows:

RESOLVED, that the KMA reaffirm its opposition to the provider tax; and be it further

RESOLVED, that the KMA maintain as a top legislative priority the repeal of the provider tax by the 1996 Kentucky General Assembly.

## RESOLUTION N

### Provider Tax

#### Warren County Medical Society

WHEREAS, the provider tax was enacted by the state legislature as a special tax against a single segment of the population; and

WHEREAS, the Constitution of the Commonwealth of Kentucky deems special taxes illegal; now, therefore, be it

RESOLVED, that the Kentucky Medical Association use all appropriate legal, judicial, legislative, or administrative action to overturn the provider tax.

## Recommendations, Reference Committee 3:

Reference Committee No. 3 reviewed Resolution N, Reaffirming Provider Tax Opposition, submitted by the Warren County Medical Society. The committee felt that the issues contained in Resolution N were addressed in Resolution I and recommends that Resolution N be rejected.

## RESOLUTION J

### Provision for Decision to Withhold Futile Medical Intervention by State-Appointed Guardianship Services Jefferson County Medical Society

WHEREAS, healthcare providers are confronted with patients with untreatable underlying conditions who are unable to provide guidance concerning their desire to further medical care; and





WHEREAS, certain numbers of these patients are wards of the state of Kentucky who have no family members able or willing to accept responsibility for making these decisions; and

WHEREAS, certain numbers of these patients in convalescent care centers are subjected to futile medical interventions due to the lack of authority by state guardians to decline such care; now, therefore, be it

RESOLVED, that the KMA work with the Legislature to develop a process in which decisions may be made by state guardians concerning the appropriateness or inappropriateness of the continued subjection of patients who are wards of the state to futile medical interventions on a case-by-case basis.

#### **Recommendations, Reference Committee 3:**

Reference Committee No. 3 reviewed Resolution J, Provision for Decision to Withhold Futile Medical Intervention by State-Appointed Guardianship Services, submitted by the Jefferson County Medical Society, and recommends that the Resolved be amended to read as follows:

**RESOLVED, that the KMA work with the Legislature to develop a more workable and timely process to allow decisions to be made regarding advanced directives and termination of inappropriate medical intervention in patients who are wards of the state on a case-by-case basis.**

The Committee recommends adoption of Resolution J as amended.

## **RESOLUTION O**

### **Robert Wood Johnson Foundation's Interference in Kentucky State Government Warren County Medical Society**

WHEREAS, documentation has been obtained regarding the Robert Wood Johnson Foundation's funding of various aspects of health care reform in the Commonwealth of Kentucky; and

WHEREAS, documentation has also been obtained as to the Robert Wood Johnson (RWJ) Foundation's "grants" to the Commonwealth of Kentucky and to influence health care legislation; and

WHEREAS, monies from the RWJ Foundation directly pay the salary of some state employees; and

WHEREAS, other states, such as Washington and Pennsylvania, adopted policies similar to those here in Kentucky under monetary pressure from RWJ Foundation and have since repealed those laws; now, therefore, be it

RESOLVED, that the Kentucky Medical Association make these above actions of the Robert Wood Johnson Foundation known to the citizens of the Commonwealth of Kentucky so they may judge for themselves the appropriateness of the actions of the government in drawing up health care reform legislation.

#### **Recommendations, Reference Committee 3:**

Reference Committee No. 3 reviewed Resolution O, Robert Wood Johnson Foundation's Interference in Kentucky State Government, submitted by the Warren County Medical Society. After hearing considerable testimony on Resolution O, the Committee recommends that it be rejected.

A motion was made and seconded on the Reference Committee recommendation to reject Resolution O. Considerable discussion was heard and a suggestion made from the floor to refer the background information from Resolution O to the Board of Trustees for further consideration. It was pointed out that implementing the resolution by dissemination of this information to all citizens of the Commonwealth would entail considerable expense, and the Association's resources were already committed to opposing the onerous portions of HB 250. The Speaker called for a vote on the motion to reject Resolution O; motion carried.

## **RESOLUTION E**

### **Youth Access to Tobacco Products Fayette County Medical Society**

WHEREAS, tobacco consumption is the leading preventable cause of morbidity and mortality in this state; and

WHEREAS, 85% of nicotine addicts start tobacco use before age 18; and

WHEREAS, the legislation passed by the Kentucky General Assembly during the 1994 session does not contain adequate enforcement provisions and prevents local communities from passing more adequate measures; now, therefore, be it

RESOLVED, that the KMA support efforts to pass more appropriate

legislation during the 1996 legislative session that would increase the fines for illegal sales to minors so that enforcement efforts would be justified, that would allow standard law enforcement agencies to enforce these sales restrictions, and that would allow local communities to pass more stringent laws if they feel it is appropriate.

#### **Recommendations, Reference Committee 3:**

Reference Committee No. 3 then considered Resolution E, Youth Access to Tobacco Products, submitted by the Fayette County Medical Society. The Committee voted to amend the existing "Resolved" by inserting the word "tobacco" between "illegal" and "sales" so that the amended Resolved will read as follows:

**RESOLVED, that the KMA support efforts to pass more appropriate legislation during the 1996 Legislature that would increase fines for illegal tobacco sales to minors so that enforcement efforts would be justified, that would allow standard law enforcement agencies to enforce these sales restrictions and that would allow local communities to pass more stringent laws if they feel it is appropriate; and be it further**

The Reference Committee further recommends that a new Resolved be added as follows:

**RESOLVED, that the KMA further support the proposed FDA regulations specifically by writing a letter of support during the public comment period, which ends on November 9.**

Reference Committee No. 3 recommends adoption of Resolution E as amended.

Mr Speaker, Reference Committee No. 3 recommends the adoption of the report of Reference Committee No. 3 as a whole.

Mr Speaker, I wish to thank the other members of Reference Committee No. 3 for their participation in the review of these issues. They are: David W. Douglas, MD, London; Joseph H. Harpole, Jr, MD, Henderson; Carolyn S. Watson, MD, Paducah; Brenda I. Townes, MD, Louisville; and Charles T. Watson, MD, Ashland. Reference Committee No. 3 would also like to express its appreciation to Debbie Best for her assistance in preparing this report.

Respectfully submitted,  
REFERENCE COMMITTEE NO. 3  
Thomas E. Bunnell, MD, Erlanger, Chair  
David W. Douglas, MD, London  
Joseph H. Harpole, Jr, MD, Henderson  
Carolyn S. Watson, MD, Paducah  
Brenda I. Townes, MD, Louisville  
Charles T. Watson, MD, Ashland

## **Report of the Chair**

### **KEMPAC Board of Directors**

Let me begin by thanking the 1000 plus physicians who have joined KEMPAC this year. The Committee of 1000 represents approximately 15% of the practicing physicians in Kentucky. Those physicians by and large stand alone in a sea tide of change that is inundating our profession and our patients. Medicine, as many of us know — occasionally painfully — is undergoing profound changes. Many of us here tonight witnessed the golden age of medicine — particularly the years from 1966 to 1990. The unprecedented growth of medical technology, drugs, procedures, and advancement in patient care lengthened lives, increased quality of care, and alleviated pain. The medical profession experienced a tremendous explosion in specialties, subspecialties, and super specialties. The cost of health care, with few restraints, skyrocketed and created an unbearable burden for business and government, the major funders of health insurance. In the late 80s the "stork outran the plow" and the clammer for reducing medical costs which began as a whimper exploded into a crescendo of criticism centering upon us — the physicians. The revolution has become an evolution in the delivery of health care.

The gradual and subtle transformation in medical practice, particularly managed care, has risen to epic proportions in some areas of the United States. Some of these changes are already affecting physicians, particularly in Kentucky's urban areas. The metamorphosis of medical practice did not occur in a vacuum. The majority of changes we have witnessed came about as a result of activities in the halls of Congress and the Chambers of the



Kentucky General Assembly. Year after year, your National and State Legislative Chairs, Don Barton and Wally Montgomery, warned of the growing tide of opposition. The horrendous cost of Workers Compensation and group health insurance have alienated the business community from medicine. The invisible barrier between medicine and business is in my opinion the most serious crisis within the profession. **Probably very few of you are aware that the Kentucky Chamber of Commerce endorsed House Bill 250 in its final form.** This has to be a wake-up call for each and every one of us to join our local Chamber of Commerce and begin serious dialogue with our business friends. Congress enacted ERISA, which permitted self-insured groups and released major industries and employers from the burden of state health insurance regulation and permitted employers to determine group insurance plans. Essentially the employer determined how, where, and when their employee entered the health care arena. RBRVS, DRGs, managed care, massive reductions in Medicare reimbursement have all been proposed and enacted by a conservative business-oriented Reagan and Bush Administration. Now we learn that Congress — the House — is proposing 100 billion dollar cuts in Medicare alone, developing block grants to states for Medicaid — and arbitrary changes in funding of medical schools. I don't have to paint the picture in any more detail to clarify who will bear the brunt of these cuts. These issues are not raised here tonight to inflict partisan politics in our discussion — but only to point out that the playing field as we have known it has been altered. Our friends are now our foes — and our foes may well become our friends. However, I am convinced that one group remains solidly in our corner — our patients. Unfortunately, the public rarely, and usually too late, gets involved in the political process. That's where you and I enter the picture — that's where we, together, can really make a difference.

Since 1962 KEMPAC has operated as the political arm of Kentucky medicine. Over the years a small cadre of physicians, usually less than 800, carried the profession. Routinely the powerful 800 paid their \$100 per year and together contributed approximately \$100,000 in biennial election cycles. Fully 50% of our dues went to AMPAC to support our United States Senatorial and Congressional candidates. We have had outstanding support from our Washington delegation and we can all tip our hats to the KEMPAC members for forging that alliance. Until campaign and election reforms, along with lobbying restrictions, decimated Kentucky PACS and Associations' traditional operations, KEMPAC and KMA had unprecedented success in the Kentucky General Assembly. In 1994 you and I witnessed in a cruel and devastating manner the arrogance General Assembly members and others had for our views when they no longer faced nor feared the wrath of medicine's political operation.

So — that's history. Where do we go from here? Simple — we return to our roots — political education, political involvement, and our understanding and acceptance that medicine is forever and irrevocably tied to the political arena. Buck passing comments made by the uninformed, such as "I detest politics or 'I refuse to become involved,'" are simple excuses for indifference. **Is there anyone here tonight who knows of or can develop a better political system than Thomas Jefferson devised?** The problems with government are not politicians — the problems with government are constituents who don't vote — don't participate — don't contribute. If there are inequities in our political system, they are the result of apathetic constituents, which in turn spawn politicians who lack respect for voters.

KEMPAC, recognizing the changes brought about by "PAC" reform has embarked upon a new and restructured course. From this day on, education — political education of physicians and spouses — will be the primary focus of KEMPAC. We will teach every physician, spouse, or family member who is interested, how to run for political office — how to manage another candidate's campaign — how to work effectively in a campaign. The KMA Alliance at our request is in the process of a massive voter registration drive, registering physicians, spouses, and others. We will continue our strong role in funding congressional candidates. We intend to closely monitor and report voting records and assist in targeting General Assembly members whose votes reflect an anti-patient, anti-physician sentiment.

However, the 1000 plus physicians who joined this year need help. Our new goals will be costly to implement and maintain. While we are pleased to report that in 1995 we surpassed all goals in terms of membership established by AMPAC, this is only a beginning.

Tonight I urge each and everyone of you to join. Join tonight. One

hundred dollars a year — 28 cents per day — \$12.00 per month is a small price to pay to retain the profession and protect our patients. If you don't have a personal check, see Jeanette Thompson out at the KEMPAC desk and ask her to bill you. We would like to send a message this year to those who represent us that we are angry — but our anger is controlled and will be directed toward positive action. We intend to double our membership in '96 to assure that we are represented by politicians who genuinely respect the profession and the patients we serve.

William P. VonderHaar, MD  
Chair

**Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.**

## REPORT OF REFERENCE COMMITTEE NO. 4

Joseph G. Weigel, MD, Somerset, Chair

28. Report of the Committee on Medical Insurance and Prepayment Plans
29. Report of the Committee on Claims and Utilization Review
30. Report of the PRO Advisory Committee
31. Report of the Committee to Investigate Changing Trends in Medicine
32. Report of the Organization Study Committee
33. Report of the Young Physicians Steering Committee
34. Report of the Resident Physicians Section
35. Report of the Medical Student Section
- Resolution D — Insurance Coverage for Obstetrical Care (Board of Trustees)
- Resolution F — Statewide Health Information Network (Fayette County Medical Society)
- Resolution H — Patient Protection and Preservation of Choice (Board of Trustees)
- Resolution L — Standard Physician's Service Agreement (Jefferson County Medical Society)
- Resolution U — Insurance Coverage for Obstetrical Care (Pulaski County Medical Society)

### ITEMS FOR CONSENT

Reference Committee No. 4 reviewed the following items and recommends they be filed, by consent of the House, without discussion:

28. Report of the Committee on Medical Insurance and Prepayment Plans — filed
29. Report of the Committee on Claims and Utilization Review — filed
30. Report of the PRO Advisory Committee — filed
31. Report of the Committee to Investigate Changing Trends in Medicine — filed
32. Report of the Organization Study Committee — filed
33. Report of the Young Physicians Steering Committee — filed
34. Report of the Resident Physicians Section — filed
35. Report of the Medical Student Section — filed

Mr Speaker, Reference Committee No. 4 recommends adoption of the Consent Calendar as a whole.

Reference Committee No. 4 would like to express its appreciation to the authors of the reports which have been filed for their time and effort spent in gathering this information for the House of Delegates.

## Report of the Committee on Medical Insurance and Prepayment Plans

The Committee on Medical Insurance and Prepayment Plans met on two occasions this year, November 16 and April 5. In the interim, your Chair and staff met on several occasions with representatives of the KMA Insurance Agency in an effort to make the KMA-endorsed Blue Cross and Blue Shield plan for the membership more attractive.

Blue Cross and Blue Shield has worked with KMA and KMA Insurance Agency in an effort to develop a special KMA plan that would offer attrac-





tively priced coverage, be unique only to KMA's group, and stimulate enrollment growth. A number of conceptual approaches have been discussed including having two or three tiers (varying premiums and benefits for principals and employees), managed care for office staff, professional courtesy among physicians only, and limited prescription drugs for the physician segment. Progress in these areas has been slow but we continue to work to improve the plan for the membership.

The committee changed the renewal date for the KMA group plan from February 1 to June 1. The primary reason was to allow more time to develop plans that were offered this year. A secondary benefit of that extension was that the Health Policy Board adopted four basic benefit plans and after July 15, 1995, any plan sold in the state will have to reflect the makeup of those standard plans. Because KMA's re-enrollment was in June, it will not have to comply with the state coverage requirements until June, 1996.

Over the years, the committee has been told that for the plan to become more stable and to have more predictable rate adjustments, the plan must grow. That means an aggressive advertising campaign needs to be undertaken, with the product being explained and sold face to face. In the past, the KMA Insurance Agency has not been in a position to do that. However, this year they have developed a significant marketing plan, have budgeted for an emphasis on sales and marketing, and have arranged to have several people assigned full time to the program during the renewal period. This effort, coupled with a more attractive pricing structure, will hopefully have beneficial results for the membership.

In past years, Blue Cross and Blue Shield adjusted rates based on the average experience of the entire group. This year Blue Cross and Blue Shield suggested that each component plan be rated on its own experience. This, unfortunately, resulted in a significant increase for the higher cost indemnity plan, but a less aggressive increase for the Option 2000 plans.

The most comprehensive, and expensive, option offered is a traditional indemnity plan with a \$300 deductible and completely free choice of hospital and physician, including hospitals outside the state of Kentucky which have no contracts with Blue Cross and Blue Shield. The plan pays whatever hospitals charge as long as the service provided is a covered benefit. The Agency did an analysis of the expenditures in this option, compared to the two Option 2000 plans also offered, and found that the expenses generated by 600 contracts in the high cost plan were about the same as the expenses generated by 1000 contracts in the two other plans. While more expensive, the committee believes the indemnity plan is attractive to some members and it continues to be an optional offering.

Over the years, the Agency has told the committee that physicians continually ask for plans with higher deductibles. This year, we were able to respond to that request and offer a fourth option. That new plan carries a deductible of \$750 for single coverage, \$2250 for family. The \$1000/\$3000 out-of-pocket maximum is maintained. Co-insurance is 70/30 compared to the other plan's 80/20. This plan also has a \$250 copayment for each inpatient admission. Because physicians have told the Agency that they are not interested in outpatient prescription plans, the plan includes a \$250 deductible on prescriptions. There is a \$25,000 lifetime maximum on nervous and mental benefits and a \$2,000,000 lifetime maximum for all other coverages. This plan is being offered at a significantly lower premium, again, to meet the needs expressed to the committee by the membership.

The Agency negotiated a one-time transfer from the high option plan to any of the three Option 2000 plans without medical underwriting for this year only.

#### House of Delegates Referrals

##### Resolution K — Insurance Industry Liaison

Resolution K was adopted by the House of Delegates in 1993 and referred to this committee. Resolution K asked the committee to develop a closer liaison with major carriers.

The Committee on Medical Insurance and Prepayment Plans has and will continue to work to develop appropriate relations with the major insurance carriers in Kentucky. The committee will renew its efforts to meet with key personnel with major carriers on a periodic basis. One problem in implementing this resolution is that there are only two major carriers headquartered in Kentucky. While representatives of those carriers are willing to meet with the committee, it is often impossible to get individuals with decision-making authority with other carriers to meet with us.

##### Resolution J — Assistants at Surgery

Resolution J was adopted by the House in 1993 and referred to this committee to collect guidelines from medical specialty societies on the appropriate use of physicians as assistants at surgery, and report the results of that study to the Board with a recommendation on how the information could best be utilized.

The committee wrote to every major surgical specialty group requesting this information. Some groups had no guidelines, others sent guidelines that were extremely vague, while others sent voluminous information. That information is available from the Headquarters Office. It is the committee's feeling that the information as collected is so diverse as to be of little use for broad dissemination.

The committee recommended to the Board, that as a general policy, the attending surgeon is the individual best qualified to determine whether or not an assistant surgeon is needed, and if so, the physician serving as assistant surgeon should be compensated fairly.

Since it is likely that this type of issue will be considered by the Health Policy Board in its development of practice parameters, we encourage specialty societies to take an active participatory role in those discussions to the extent possible, if and when they take place.

##### Resolution A — Provider Tax

Resolution A was adopted by the House in 1994. The first "resolved" was referred to this committee and it states: "that the Kentucky Medical Association shall design and disseminate a strategy to allow physician providers to pass through the tax imposed on physician gross revenues by the 1994 HB 250."

The author of Resolution A is a member of our committee and reported that the intent of the "resolved" was to identify those insurance carriers that would allow a pass through of the tax. If most carriers do not allow a pass through, KMA will have documentation which can be shared with the Kentucky General Assembly. It was felt this "resolved" could be accomplished by KMA writing carriers on behalf of the membership or by developing a sample letter which individual members could use to make inquiry.

The committee agreed to ask legal counsel's guidance on this matter and subsequently, a letter was sent over President Goodin's signature to major carriers in the state. The letter noted that the fact that the 2% tax on providers had been enacted by the Kentucky General Assembly and asked for each major carrier's policy regarding the ability of physicians to pass the tax through in the form of adjusted fees. Fourteen carriers were contacted and four responded. As anticipated, all stated, for various reasons, that they would not allow the tax to be passed through. The committee recommended to the Board that these responses be passed along to the State Legislative Committee.

As Chair of the committee, I appreciate the continuing participation of the committee members and the assistance of the staff of the KMA Insurance Agency.

**Donald R. Neel, MD**  
Chair

## **Report of the Committee on Claims and Utilization Review**

Claims and Utilization Review Committee activities this year have been focused on specific issues rather than the ongoing review process. The proliferation of managed care plans continues to diminish regular review activities. As managed care plans expand fee profiling efforts, few questions arise regarding contended reimbursement. And while practice parameters do not exist in any comprehensive form, major carriers have often defined appropriate practice patterns through terms of payment algorithms.

The committee continues to seek a focused role for its attention in the context of growing medical care plans. At this point, it is unknown what effects the health care reform insurance provisions may have on the viability of independent physician review, but it is hoped that the necessity for peer review will become more fully defined as practical health care reform issues are resolved.

Continuing efforts have been made to identify a role for independent peer review in association with the Medicare Part B carrier. Some consideration has been given to the development of review/educational opportunities for peer review in this area, which would focus on specific procedures and treatment patterns.



Some efforts have been devoted this year to developing an independent review process to be made available to the state Workers' Compensation program. Independent physician review has been used by this program intermittently in the past. In past years the Workers' Compensation program has been subject to social, economic, and political attention and pressures, and has received considerable legislative scrutiny. It is hoped that a formalized independent review process can be finalized and used for Workers' Compensation claims routinely.

As other review matters develop, the committee will give attention to them, as needed, and appreciates the support of the Board of Trustees.

**K. Thomas Reichard, MD**  
Chair

## Report of the PRO Advisory Committee

The PRO Advisory Committee was established to provide liaison with the professional review organization for Kentucky for KMA, and to be an advocate for physicians to this federal agency. The Kentucky Medical Review Organization is affiliated with the Indiana Medical Review Organization. IMRO is the parent agency which holds a contract to perform PRO activities in both Indiana and Kentucky. As currently constituted, the governing board of IMRO consists of 15 members, 7 of whom are Kentucky physicians. There are also 6 Indiana physicians, and 2 nonphysicians who are residents of Indiana.

The bulk of work by KMRO this year has been devoted to the Health Care Quality Improvement Program, the so-called Fourth Scope of Work. The Fourth Scope of Work is devoted to analysis of treatment patterns, as indicated by retrospective data review. Formerly, the PRO was charged with conducting intensive review of individual medical records, and the PRO is currently charged with some random record review and with investigating beneficiary complaints. Under the new Fourth Scope of Work, the PRO is to identify and interpret sound practice parameters and measure quality of care, based on treatment outcomes, as indicated by the records. This information, once accumulated, will be shared with hospitals and doctors in an educational fashion. The overall purpose of this activity is to improve the quality of care and reduce costs by determining the best practices and by encouraging physicians and hospitals to engage in these practices rather than from identifying errors.

To accomplish the massive data collection necessary, the Health Care Financing Administration has let two contracts for clinical data abstraction nationally to two different firms. The firm that will collect Kentucky data is Dyn/KePro. Information is being collected from hospitals on patients after discharge. Although a significant amount of information has been collected, the actual materials will be approximately 30% less than data collected from previous years. Hospitals are being reimbursed for data collection efforts.

In line with this new overall work by the PRO, an interview was conducted with staff by the Arthur Andersen Company and representatives of the Health Care Financing Administration. The purpose of the interview was to determine the interest of the medical profession, generally, in clinical outcomes research and to try to develop some overall idea of its value and acceptability in clinical practice. Theoretically, such information would obviously be invaluable.

One of the first efforts in this data collection exercise is the Cooperative Cardiovascular Project, which has been initiated by KMRO. Begun at the first of the year, this project is directed to collecting information relating to diagnoses and procedures on acute myocardial infarction. Data being collected for this project relates to seven factors, to be determined at the time of hospitalization, which are:

1. Confirmation of the acute myocardial infarction;
2. Use of thrombolytics;
3. The timing of thrombolysis;
4. The use of aspirin during hospitalization;
5. The timing of the use of aspirin;
6. The use of heparin;
7. The use of nitroglycerin.

Information on five factors at the time of discharge are being gathered, which are:

1. The use of aspirin at discharge;
2. The use of beta blockers;
3. The use of ACE inhibitors;

4. Avoidance of calcium blockers;

5. Smoking cessation counseling.

To assist on the Cooperative Cardiovascular Project data-gathering efforts, KMRO held a series of seminars in May to explain the general focus of the quality improvement program and specifics on the Cardiovascular Project.

With the shift in focus of PRO efforts to data gathering and, ultimately, compilation of practice parameters, there has been a reduced need for direct advocacy on behalf of physicians because there has been less intense scrutiny of individual physician efforts. Theoretically, the Health Care Quality Improvement Program is quite positive, particularly if it results in the development of practice parameters based on actual outcomes review rather than practice parameters developed by consensus.

The PRO Advisory Committee and the profession will look anxiously on both direction and outcome of this effort.

**William H. Mitchell, MD**  
Chair

## Report of the Committee to Investigate Changing Trends in Medicine

The Committee to Study Changing Trends in Medicine met on Thursday, April 27, 1995. The committee's mission is to study and report on evolving delivery and payment mechanisms; to study and report on demographic trends affecting medical practice; to study and report on ethical questions regarding financial considerations versus quality of life; to investigate trends in cost containment activities; and to determine, to the extent feasible, the role of organized medicine in this changing environment.

This year, the committee focused on the issue of Electronic Data Interchange (EDI). EDI has become widespread and increasingly user friendly. Anyone who has used an automated teller machine at a local bank has participated in an electronic data interchange process. EDI applications for medical practice in the future are significant. Electronic medical records will provide immediate access to patient histories, help practitioners avoid duplicate tests, and allow the practice to administer benefit rules more efficiently. Telemedicine will provide both specialty consultation and continuing medical education for physicians practicing in underserved areas. Clinical information systems will become more useful and relevant to clinicians. Using Electronic Data Interchange, the progress of a patient can be followed through an integrated delivery network from office visit, to inpatient care, to ancillary services, and produce a comprehensive summary of that episode of illness.

While this sounds promising, we know that some of these ideas will be too expensive and have little practical applicability to become widely used. The committee wanted to learn more about the current status of the use of Electronic Data Interchange in the United States as well as the potential for the concept in the future.

The committee was fortunate to have Lynn E. Jensen, PhD, Vice President, Strategic Advocacy Management, for the American Medical Association, meet with them. Dr Jensen is the American Medical Association's representative to various agencies dealing with EDI issues. His role is to assure that the physician's point of view is articulated as efforts are made to deal with various EDI issues.

Dr Jensen reported that, currently, surgical specialties tend to use EDI more than other specialties. Physicians practicing in small communities are more likely to use the technology as are younger physicians. Although technology is widely available, usage is comparatively small. Less than 20% of all claims are submitted electronically. One reason is that over 400 formats are currently required for claims processing; and there is continued concern about confidentiality, as well as the cost effectiveness of purchasing, installing, and operating a system. Rapid and expensive technology changes make many physicians wary of investing a sizable sum of money in an office-based system which could become obsolete in a very short period of time.

AMA's EDI goal, as approved by the House of Delegates in December 1994, is: *The rapid development of a low cost means for physicians to exchange claims and eligibility information and remittance advice with payors and others.*

AMA's EDI strategy includes using incentives rather than sanctions or penalties; promoting uniform claims data sets; pursuing standardization by





getting rid of the 400+ formats; implementing realistic timetables; and most importantly, protecting confidentiality.

The AMA is implementing its strategy by participating in forums and by informing and assisting physicians through educational processes such as written material and seminars. Other AMA activities include the development of a Physicians Guide to EDI, coordinating organized medicine's policy on EDI, developing and publishing focused booklets on various EDI issues and using *AM News* to bring EDI issues before physicians on an ongoing basis. The development of an AMA Federation Forum will solicit direct input from state societies regarding local EDI issues.

The AMA, working with HCFA and other entities, has created a National Uniform Claim Committee to establish a standard electronic claim form for all payors. The committee will be chaired by AMA in partnership with HCFA, will parallel the National Uniform Billing Committee, and will be composed of major payors and providers. Its goal will be to establish a standard electronic claim form for all payors.

The AMA is also heavily involved in clinical applications for EDI. Computer-based patient records enhance speed of access and have the potential to serve as a central point for all of a patient's medical history. Telemedicine is gaining wider acceptance, although it is currently used by two or three specialties, predominantly radiology and pathology. However, it has been reported that several large clinics, for example the Mayo Clinic, use telemedicine routinely to provide consultative and continuing medical education services to its satellite clinics.

The major goal of telemedicine is to improve access to specialty care in rural areas and to lessen the need to send patients away from local areas for care. However, some payors are unsure of what telemedicine services they should cover and how those services should be paid. There are also questions regarding licensure. If the consultant is located in a different state, is the consultant required to be licensed in the same state in which the patient is located, or is the patient effectively "electronically transported" to the consultant's location? It was felt these issues were not insurmountable but do need resolution before telemedicine is used in a broader fashion.

Another concern is the cost of bringing the widespread use of this technology into reality. Individuals and organizations are exercising caution, fearing that software bought today may not be compatible with that eventually embraced throughout the health care system. Thus, the financial issues involved must be a priority as the process moves forward.

A significant amount of Electronic Data Interchange is transmitted on the so-called Internet. The Internet was started by the government in the 1970s to link high performance computers located mainly in research facilities and military installations. It has been reported that there are now over 32,000 networks making up the Internet, which link 15 million users on 3 million computers. That concept is now developing into the national information infrastructure, which in the future will blend cellular, cable TV, computers, and other electronic communication devices into one compatible network. Currently, there are a number of activities available through the Internet while others are in the experimental stages. Perhaps one of the most widely known is the National Library of Medicine, MEDLARS On-Line Network. Two major components are available to physicians. Grateful Med allows on-line searches by personal computer. Currently seven million searches are done per year, one half related to individual patient problems, the other half related to research. The second component is called Lonesome Doc and is designed for physicians in locations with limited consultation availability.

Work is underway on a computerized unified medical language system. This will attempt to take all currently used medical terminology and place it into a computer. There will be 191,000 clinical concepts and 372,000 terms which can be accessed. The Visible Human project will provide computerized images in any dimension of the human body.

A Community Health Information Network (CHIN) is a regional electronic network linking all health care participants in the area, including hospitals, doctors' offices, outpatient clinics, home health care agencies, insurers, and employers. A CHIN provides the data, voice, and image network that supports a region's delivery system. There are essentially two approaches to these networks. The first electronically transfers patient eligibility and claims processing data. The second includes a clinical data repository. In some cases, CHINs are developed as partnerships between various entities. Some are proprietary, in which case, subscriptions are sold to various entities which may want to use the network. Prescriptions can be

electronically relayed to connected pharmacies, hospital records can be updated from the physician's office, attestations can be done electronically, and hospital lab results can be transferred electronically into the physician's office via a personal computer. A patient's hospital record can be accessed from various sites. It is estimated that every time a hospital medical record is retrieved, manually updated, and restored it costs about \$8.00. Thus it appears there are substantial savings to be gained. However, this is based on the assumption that the computer system and usage cost will be less than that currently in effect.

While the potential benefits of CHINs are many, there may be some non-technical obstacles that could impede the adaptation of these networks as a primary means of exchanging health-related information. The capital investment required to establish these links, transaction fees, and the purchase or upgrade of existing hardware and software could be substantial. In a competitive environment, questions may arise about ownership and governance of the network and the sharing of potentially strategic information. Privacy and security of patient information may be a concern. However, even in light of these potential problems, the concept seems to have merit and bears further study as a means to reduce administrative cost. This will become increasingly important as capitated payments expand and practitioners look for ways to become more cost efficient.

Electronic Data Interchange is one more part of the rapid change taking place in medical practice today. Technology has become widely available, easy to use, and relatively inexpensive. Payors have learned that electronically submitted claims are much less expensive to process, and many are moving rapidly towards a requirement that all claims be submitted electronically. Systems are being developed that have extensive security systems which will provide the confidentiality of patient records which physicians demand. Some even feel that confidentiality methods used in electronic processing are superior to that currently available with paper claims. Clearly physicians and their staffs need to be aware of these changes and use them as advantageously as possible.

I appreciate the ongoing interest of the committee members and the excellent presentation made by Dr Jensen.

**Marjorie Fitzgerald, MD**  
Chair

## Report of the Physician Organization Study Committee

The Physician Organization Study Committee was formed after the adoption of Resolution B by the 1993 Kentucky Medical Association House of Delegates. Resolution B called for the Kentucky Medical Association to:

1. Initiate a study of the feasibility of establishing a physician-owned and directed economic entity which allows all KMA members the opportunity to participate in delivery and payment systems evolving from health system reform measures;
2. Consider legal, professional, and financial requirements of establishing a physician-owned and directed economic entity, as well as the corporate structure, philosophy, and future relationships with KMA and affiliated organizations;
3. Engage the services of appropriate consultants, as required, to help determine the advisability of such an organization, as well as levels of professional and financial support deemed necessary to assure fiscal viability.

During its first year of existence, the committee met on numerous occasions to develop a plan of action. As reported to the House of Delegates in 1994, the committee developed the following short-term action plan:

1. Publicize AMA's Doctors Resource Service (DRS), which was designed by AMA specifically for physicians involved or considering involvement in managed care.
2. Make committee members and staff available to speak to interested groups of physician members across the state. Staff could develop the text and some accompanying slides. (It should be noted that a presentation has been developed and presented to various physician groups throughout the state.)
3. Begin research on the status of managed care, physician organizations, and nonphysician organizations in Kentucky. There is no central source of information readily available currently.
4. Influence the market in Kentucky by helping to influence the structure



that is negotiated by recommending physician-friendly firms (legal, financial, business, actuarial consultants) to perform certain services. KMA can serve as a central reference point to put doctors together with competent advisors.

5. Sponsor managed care seminars on a statewide, regional, or local basis using consultants interviewed and "endorsed" by KMA.

The committee has made every effort in the past year to comply with this comprehensive plan. In fact, extensive efforts have gone into implementing all five facets of the plan of action. These efforts were highlighted by the presentation of a joint KMA-AMA interactive managed care workshop in Paducah in May. This workshop was well-attended and provided many Kentucky physicians with much needed information regarding managed care. The Paducah workshop complemented similar presentations made last year in Richmond and Louisville. The committee is currently planning a full day seminar on managed care for later this fall in Lexington. This seminar should expand upon previous committee educational efforts and provide physicians with the latest managed care developments and information.

Among the long-term goals agreed to by the committee in 1994 were:

1. Explore ongoing educational activities, to include quality assurance and outcomes measurement; development and ongoing refinement of practice parameters, utilization review, and appropriate CME opportunities.
2. Explore arrangements which might offer some benefits of a physician organization without the financial commitments required by some types of physician organizations (ie, partnerships, joint ventures).

In regard to these long-term goals, the committee continues to work with all available groups (ie, AMA, Kentucky Health Policy Board, Kentucky Department of Medicaid Services) to meet these objectives.

Other issues of importance that highlighted the committee's year included the concept of converting Kentucky's Medicaid program to managed care. CHR Secretary Masten Childers met with the committee to explain his Medicaid managed care proposal. In this plan, "health care partnerships" would be set up in various regions of the state. These partnerships would design the Medicaid delivery system for their individual region and design payment methodology. As any plan to convert Medicaid to managed care would require a waiver from the federal government, the committee agreed to take no position on Secretary Childers proposal until such time as a formal waiver request is made which explains this initiative in much more detail.

Last year the committee recommended that KMA not develop an insurance-based entity. This recommendation still stands this year. The challenge of setting up an insurance-based physician organization is formidable. It is expensive to establish. No matter how much physician support is given these entities, they will still have the general characteristics of insurance companies. They will need to market their product to the buyers, requiring sales representatives and other marketing assistance. They will need a way to collect and distribute money, requiring administrative assistance, computers, and management personnel. They will need a way to judge that the premiums paid will be enough to meet their financial obligations, which means hiring actuaries and building reserves in addition to generating enough funding to cover initial start-up costs.

Among the ideas the committee will be exploring in the coming year will be development of a KMA Management Services Organization (MSO). The MSO concept would allow for an expanded educational and assistance role for KMA in its efforts to educate Kentucky physicians about managed care and its potential effect on their medical practices. The committee plans to utilize other state medical societies who have implemented MSOs as a resource during this study process.

This has been an active year for the committee, and I foresee 1996 as no different. The committee will continue to study and explore methods to meet the charge of Resolution B (1993). There is a window of opportunity for Kentucky physicians to have some control over their futures in a managed care environment. Keep in mind that only physicians are licensed to practice medicine and, therefore, they will be a major player in all emerging health care delivery systems. The committee will continue its efforts to help KMA develop the best available means to meet this goal.

As Chair, I appreciate the active participation of the members of the committee and their commitment to the committee's goals and responsibilities.

**Robert R. Goodin, MD**  
Chair

## Report of the Young Physicians Steering Committee

The Young Physicians Steering Committee held two meetings this year, with a third one scheduled prior to KMA's Annual Meeting. The purpose of our committee is to discuss ways to identify and address issues of interest to young physicians and increase young physicians' involvement in organized medicine.

Our committee works in conjunction with the AMA Young Physicians Section which was formed in 1987 to provide young physicians a direct voice in policy decision making in all levels of organized medicine. Kentucky sends a YPS Delegate to the Annual and Interim Meetings of the AMA House of Delegates. We have found it very helpful and enlightening to participate directly in establishing policies that will affect our careers.

This year, the AMA Young Physicians Section asked for nominations for young physicians who had demonstrated outstanding community service by undertaking leadership roles in community health projects. The committee proudly submitted the name of Baretta Casey, MD, a member of our committee and Chair of KMA's Subcommittee on Domestic Violence. Dr Casey has been widely recognized in Kentucky for her work in this area, and we felt that she was an excellent representative of the type of individual the award was designed to recognize. We are pleased to report that Dr Casey was one of five recipients honored by the AMA-YPS during the Annual Meeting in June. We are extremely proud of her accomplishments which we believe reflect favorably on all physicians in Kentucky.

The committee also held a young physicians luncheon last year during the Annual Meeting and was pleased to have Charles Cronan, JD, KMA's outside counsel, as our speaker. Mr Cronan discussed contracting issues which were of significant interest to the 50 young physicians who attended the program. We are planning to hold the luncheon again this year at noon on September 19 in the Lexington Room of the Hyatt Regency in Lexington. Any young physician member of KMA is welcome to attend. The committee would like to acknowledge, with appreciation, the generous sponsorship of the luncheon by the Kentucky Medical Insurance Company.

This year, we will again use special ribbons to identify young physicians attending the KMA Annual Meeting. The AMA defines young physicians as being under the age of 40 or in the first five years of professional practice.

The committee appreciates the continuing support of the KMA Board of Trustees and the officers of the Association.

**Ford Threlkeld, MD**  
Chair

## Report of the Resident Physicians Section

The KMA Resident Physicians Section has been involved in numerous activities at the state and national levels this year. Representatives from the residency programs at the University of Louisville, University of Kentucky, Trover Clinic, and St. Elizabeth's form the section's Governing Council which meets regularly to discuss matters of concern to residents in Kentucky and in the nation.

The council met four times this year, with the first meeting held during the 1994 KMA Annual Meeting to discuss the RPS resolution and other issues to be brought before the KMA House of Delegates. The council continues to be successful in effecting policy at the state level and, since 1984, has had resolutions adopted at every state meeting. The 1994 House adopted an RPS resolution calling for training opportunities for medical students and residents on impairment prevention. We are pleased to report that this has resulted in additional programs being conducted by Burns Brady, MD, Director, Kentucky Physicians Health Foundation, Impaired Physicians Program, at several residency programs in the state as well as the 1995 House-staff Orientation session at the University of Kentucky.

The third annual joint session of the KMA sections for medical students and residents was held September 20, 1994, and featured a panel discussion on physician workforce planning from the viewpoints of medical students, residents, and practicing physicians.

New officers were elected at the February 13 meeting in which discussion took place on AMA-RPS activities, future direction of the council, participation in housestaff orientations, membership, and involvement in state legislative activities during the General Assembly.

The council met again on April 18 to formulate plans for the 1995 MSS/





RPS joint meeting in the fall and to finalize a resolution proposal for the 1995 AMA-RPS Annual Meeting. The resolution, which called for AMA to encourage medical schools and residency training programs to allow medical students and residents time to vote, was adopted by the AMA-RPS House in June for internal implementation.

The RPS meeting on July 11 centered on upcoming KMA Annual Meeting activities, including the MSS and RPS program to be held September 19 at the Lexington Civic Center. The program, "Managing to Care in Managed Care," will feature a symposium to deal with various aspects of managed care, ie, ethics, the industry's side, governmental aspects, and firsthand experience from a primary care physician who has practiced in a managed care environment.

KMA's involvement at the national level continues to grow and we are pleased to report that Judy Linger, MD, current RPS Delegate to the KMA, after her election at the Interim Meeting in December, assumed the office of Chair of the AMA-RPS Governing Council at the June Annual Meeting.

In addition, Robin Floyd, MD, was honored at the June meeting as a recipient of a Burroughs Wellcome Company Leadership Program Award. The award is given to residents who have demonstrated a commitment to civic or medical community issues through voluntary activities and have an interest in organized medicine.

Five representatives from Kentucky attended the 1995 AMA-RPS Annual Meeting, June 16-17, and we wish to thank KMA and the residency programs at the University of Louisville and University of Kentucky for providing funding for resident participation.

In late June, KMA once again participated in the Housestaff Orientations at UK and UL. We are grateful to Dr Linger who represented us at the June 27 program at UK and to KMA President Robert R. Goodin, MD, for his presentation at UL on June 29.

As President, I want to thank the individual members of the Governing Council. We have had excellent participation at all the council meetings this year and I appreciate the extra time and effort given to participate. On behalf of the council, I wish also to thank the KMA Officers, Board of Trustees, and House of Delegates for their continued support and for giving residents the opportunity to have a voice on issues affecting the future of our profession.

**Robin Floyd, MD  
President**

## Report of the Medical Student Section

The KMA Medical Student Section has been very active this year in activities at all three levels of organized medicine. At the state level, the Governing Council, which is composed of five voting members from each of the medical schools, met in September, November, and March to discuss matters of concern to medical students in Kentucky. In addition, the council published two issues of the *KY Student MeSSenger*, informing members of current issues and activities of the two chapters.

**University of Louisville** — The University of Louisville KMA-MSS Chapter was exceptionally active this year. The year began with an outstanding recruitment of over 110 new first- and second-year members. The AMA Student Outreach Program awarded the chapter almost \$2,400 for its efforts in recruitment, with the funds to be used to allow students to attend the AMA Interim and Annual meetings.

Chapter meetings held throughout the year attracted a wide variety of speakers including KMA President Robert Goodin, MD; AMA Board of Trustees member John Nelson, MD; family physician Ronald Waldrige, MD; and Health Policy Board member Beverly Gaines, MD.

In October, the chapter organized a very successful Residency Fair with 30 residency programs from Kentucky and surrounding states setting up booths where students learned about possible fourth-year electives and residency programs. In response to an AMA "Call to Action," UL students participated in a letter-writing campaign to Congress on the student loan issue.

Service projects during the year included a Halloween party for the Home of the Innocents, a shelter for children in Louisville, and a food drive for Dare to Care that brought in 958 pounds of food. In addition, 30 students were teamed with students in the pre-med program at Central High School in Louisville to act as mentors. One-on-one and group activities provided these young students with medical role models. We plan to continue the

mentor program on an annual basis. The chapter also supported the 5K Health Care Classic to benefit the Family Place which works through intervention, education, and treatment to stop child abuse.

**University of Kentucky** — The KMA-MSS Chapter at the University of Kentucky also had a very busy and productive year. Beginning in late summer, we began recruitment of incoming freshmen which netted 86 new members making us eligible for the AMA Student Outreach Award and additional funding for student participation at the AMA meetings.

In addition to regular meetings, the chapter participated in a grassroots campaign in late September. Nearly 200 UK students joined in a letter-writing campaign to our US Representatives asking them to vote favorably on the student loan deferment issue redefining economic hardship provisions under which residents can qualify for deferment. We were pleased that both the Senate and House approved these measures which was a major victory for the AMA-MSS.

The UK chapter took part in the National Primary Care Day on September 29, in conjunction with the Association of Medical Colleges. An Information Fair was held and the UK KMA-MSS distributed pamphlets about opportunities for student externships in primary care.

Both UL and UK were ably represented at the AMA-MSS Interim and Annual meetings held in December 1994 and June 1995. We are pleased that Steven Hester, UL medical student, received the 1995 AMA/Glaxo Achievement Award for his non-clinical leadership activities. The award was presented at the AMA National Leadership Conference held in March in Washington, DC.

The KMA-MSS is grateful for the continued support provided by the KMA Board of Trustees and House of Delegates and appreciates the opportunity to have a voice at the state level and be involved in the affairs of organized medicine.

**Andrea Faulconer, UL President  
LeAnn Simmons, UK President**

## END OF CONSENT CALENDAR ITEMS

### RESOLUTION D

#### Insurance Coverage for Obstetrical Care Board of Trustees

WHEREAS, some insurers limit in-hospital obstetrical coverage to 24 hours following normal birth, which is arbitrary and potentially dangerous to newborns and mothers; and

WHEREAS, the American College of Obstetrics and Gynecology and the American Medical Association have refuted this policy on the grounds of potentially adverse medical effects on maternal and neonatal health; and

WHEREAS, clinical decisions must be based on individual patient status and medical judgement and not arbitrarily decreed based on cost containment or profit motives; now, therefore, be it

RESOLVED, that the Kentucky Medical Association reaffirms the patient/physician relationship and the ability of the physician to do what is in the best interest of the patient in accordance with the physician's clinical judgment and in accordance with appropriate medical practice standards; and be it further

RESOLVED, that in the absence of definitive empirical data, discharge following delivery should be determined by the clinical judgment of physicians rather than health insurance guidelines.

### RESOLUTION U

#### Insurance Coverage for Obstetrical Care Pulaski County Medical Society

WHEREAS, the Board of Trustees of the Kentucky Medical Association has recognized that arbitrary decisions about lengths of stay in newborns and their mothers are potentially dangerous to both; and

WHEREAS, New Jersey and Maryland have enacted legislation mandating a 48-hour stay following normal deliveries and 96 hours for Cesarean section for both mother and baby; and

WHEREAS, the American Medical Association at its June 1995 meeting agreed that there was no scientific data to support the discharge of mother and baby in 24 hours; now, therefore, be it



RESOLVED, that the Kentucky Medical Association seeks and supports legislation mandating up to 48 hours in the hospital for mother and baby following a normal delivery, and up to 96 hours in the hospital following Cesarean section without complications; and be it further

RESOLVED, that third-party payers are not to, in any way, penalize patients or physicians for adhering to these guidelines.

#### **Recommendations, Reference Committee 4:**

Reference Committee No. 4 next heard testimony on Resolution D, Insurance Coverage for Obstetrical Care, introduced by the Board of Trustees, and Resolution U, Insurance Coverage for Obstetrical Care, introduced by the Pulaski County Medical Society.

The Reference Committee heard extensive discussion concerning these resolutions and recommends that Resolution D be amended at the end of the second "Resolved," by addition of the following phrase, "; and be it further," and adding the following new "Resolved" (based on information from Resolution U):

**RESOLVED, that third-party payers are not to penalize patients or physicians for acting in the patient's best interest.**

Reference Committee No. 4 recommends that the amended version of Resolution D be adopted in lieu of Resolution U.

The Board of Trustees offered a substitute for the Resolved proposed by Reference Committee No. 4 for Resolution D. A motion was made, seconded, and carried to adopt the Board substitute Resolved. Resolution D, adopted as amended by the House in lieu of Resolution U, reads as follows:

### **RESOLUTION D**

#### **(Adopted as amended)**

#### **Insurance Coverage for Obstetrical Care**

##### **Board of Trustees**

WHEREAS, some insurers limit in-hospital obstetrical coverage to 24 hours following normal birth, which is arbitrary and potentially dangerous to newborns and mothers; and

WHEREAS, the American College of Obstetrics and Gynecology and the American Medical Association have refuted this policy on the grounds of potentially adverse medical effects on maternal and neonatal health; and

WHEREAS, clinical decisions must be based on individual patient status and medical judgment and not arbitrarily decreed based on cost containment or profit motives; now, therefore, be it

RESOLVED, that the Kentucky Medical Association support legislation that would prevent third-party payors from interfering, by refusing to pay for care, with physicians' clinical judgment regarding patient care, including timing of discharge.

### **RESOLUTION F**

#### **Statewide Health Information Network**

##### **Fayette County Medical Society**

WHEREAS, distribution of health information via computer networks will likely play an important role in medical practices in this state within the next few years; and

WHEREAS, many rural practices in this state may have difficulty accessing these computer networks without assistance from an outside party; and

WHEREAS, the KMA seems to be the organization most able to bridge the differences between various health organizations throughout the state, while still keeping the interests of physicians and their patients foremost; now, therefore, be it

RESOLVED, that the KMA begin studying and evaluating options for the development of a statewide health information network with a cost structure for participating physicians, and that these options be made available to the House of Delegates no later than the 1996 Annual Meeting.

#### **Recommendations, Reference Committee 4:**

Reference Committee No. 4 next reviewed Resolution F, Statewide Health Information Network, introduced by the Fayette County Medical Society, and recommended that Resolution F be adopted.

### **RESOLUTION H**

#### **Patient Protection and Preservation of Choice**

##### **Board of Trustees**

WHEREAS, the focus of medical care delivery currently emphasizes managed care plans based in large part on cost saving concerns; and

WHEREAS, managed care plans may abridge basic patient rights, jeopardize patient choice of physician, or prevent eligible physicians from participating in certain delivery systems, to the detriment of patients; now, therefore, be it

RESOLVED, that the Kentucky Medical Association supports the priority of patient welfare in all managed care programs and the rights of patients to be advised of:

- Services covered or excluded under a health plan printed in easily understood language;
- Requirements for preauthorization of physician services or post treatment review, which may lead to denial of coverage;
- Financial arrangements which would limit services, restrict referrals, or establish incentives not to deliver services;
- Information in an understandable format that states the percentage of premium dollars spent on direct patient care;
- Patients' ability to continue treatment with their provider of choice during the period of enrollment;
- Patients' ability to receive necessary emergency services and assurances that the plan will provide reimbursement for such services regardless of the provider's participating status in such plan with no post treatment denial;
- A grievance and appeal procedure to resolve disputes over medical necessity, appropriateness of care decisions and coverage issues; and be it further

RESOLVED, that KMA continue to advocate enactment of state laws and regulations that provide for patient protection and physician fairness in managed care organizations, to include:

- Permitting physicians to negotiate with managed care organizations, as appropriate;
- Providing for formal practicing physician input in the development and refinement of medical policies, including credentialing, utilization review, quality assurance, and benefit package;
- Requiring disclosure of all participation requirements and selective contracting decisions, and disclosure of reasons for denial or deselection;
- Providing enrollees and participating physicians with the opportunity to complete a "report card" at regular intervals regarding the quality of service rendered; and be it further

RESOLVED, that KMA supports mandatory offering of point-of-service coverage in all managed care plans approved by the Health Policy Board; and be it further

RESOLVED, that KMA work with the Health Policy Board and others, as indicated, to make point-of-service options mandatory in all non-ERISA managed health care plans.

#### **Recommendations, Reference Committee 4:**

The Reference Committee next reviewed Resolution H, Patient Protection and Preservation of Choice, introduced by the KMA Board of Trustees and heard considerable testimony about the creation of an ombudsman committee for patients. Reference Committee No. 4 recommends that the word, "mandatory," be deleted in the third "Resolved," and that the word, "available," replace the word, "mandatory," in the fourth "Resolved" so that the "Resolveds" now read as follows:

**RESOLVED, that KMA supports ~~mandatory~~ offering of point-of-service coverage in all managed care plans approved by the Health Policy Board; and be it further**

**RESOLVED, that KMA work with the Health Policy Board and others as indicated, to make point-of-service options ~~mandatory~~ available in all non-ERISA managed health care plans.**

Reference Committee No. 4 recommends the adoption of Resolution H as amended and further recommends that the concept of an ombudsman committee be referred to the Board of Trustees for further discussion.

The Board of Trustees offered a substitute for the Resolveds proposed by Reference Committee No. 4 for Resolution H. After some discussion, a motion was made, seconded, and carried to adopt the Board substitute





Resolveds. Resolution H, adopted as amended by the House, reads as follows:

## **RESOLUTION H (Adopted as amended)**

### **Patient Protection and Preservation of Choice Board of Trustees**

WHEREAS, the focus of medical care delivery currently emphasizes managed care plans based in large part on cost saving concerns; and

WHEREAS, managed care plans may abridge basic patient rights, jeopardize patient choice of physician, or prevent eligible physicians from participating in certain delivery systems, to the detriment of patients; now, therefore, be it

RESOLVED, that the Kentucky Medical Association supports the priority of patient welfare in all managed care programs and the rights of patients to be advised of:

- Services covered or excluded under a health plan printed in easily understood language;
- Requirements for preauthorization of physician services or post treatment review, which may lead to denial of coverage;
- Financial arrangements which would limit services, restrict referrals, or establish incentives not to deliver services;
- Information in an understandable format that states the percentage of premium dollars spent on direct patient care;
- Patients' ability to continue treatment with their provider of choice during the period of enrollment;
- Patients' ability to receive necessary emergency services and assurances that the plan will provide reimbursement for such services regardless of the provider's participating status in such plan with no post treatment denial;
- A grievance and appeal procedure to resolve disputes over medical necessity, appropriateness of care decisions and coverage issues; and be it further

RESOLVED, that KMA continue to advocate enactment of state laws and regulations that provide for patient protection and physician fairness in managed care organizations, to include:

- Permitting physicians to negotiate with managed care organizations, as appropriate;
- Providing for formal practicing physician input in the development and refinement of medical policies, including credentialing, utilization review, quality assurance, and benefit package;
- Requiring disclosure of all participation requirements and selective contracting decisions, and disclosure of reasons for denial or deselection;
- Providing enrollees and participating physicians with the opportunity to complete a "report card" at regular intervals regarding the quality of service rendered; and be it further

RESOLVED, that KMA advocate enactment of state laws or administrative regulations which provide for a point-of-service feature that is to be required in all managed care plans which have a closed panel and are approved by the Health Policy Board; and be it further

RESOLVED, that KMA work to make a point-of-service feature be required in all non-ERISA managed care plans which have closed panels.

## **RESOLUTION L**

### **Standard Physician's Service Agreement Jefferson County Medical Society**

WHEREAS, the business side of medicine has become increasingly more complex with the advent of managed care; and

WHEREAS, the economic reforms of medicine have led to a proliferation of new third-party insurance providers and plans; and

WHEREAS, these new economic forces have created enormous pressures on physicians to enter an increasing number of contractual arrangements with various insurance companies and plans; and

WHEREAS, this flood of contracts has taken increasingly more of the physician's time away from the practice of medicine and direct patient care; and

WHEREAS, the cost of having private counsel review every new contract, revision, or addendum would be prohibitive; and

WHEREAS, it is in the best interest of both patients and physicians to

maintain a separate and independent relationship with insurance companies so that patient advocacy and care will not be compromised; and

WHEREAS, third-party insurance payers wish to contractually transfer their medical liability in managed care arrangements to physicians; and

WHEREAS, a single, standard contract which all physicians could use to contract their services with any third-party payer would dramatically reduce physician time spent reviewing contracts and protect physicians from potentially hazardous contractual arrangements; and

WHEREAS, a single boilerplate contract (similar to a real estate contract to purchase a home) would clearly define the rights and obligations of both physician and payer and eliminate the need for repeated legal consultation regarding the terms of each new or revised contract; now, therefore, be it

RESOLVED, that the Kentucky Medical Association draft and endorse a "Standard Physician Service Agreement" that can be used statewide on a voluntary basis by Kentucky physicians in their contractual arrangements with third-party payers; and be it further

RESOLVED, that the purpose of the "Standard Physician Service Agreement" will be to set forth the rights and obligations of the physicians and insurance payers in a consistent and uniform fashion throughout the state; and be it further

RESOLVED, that the "Standard Physicians Service Agreement" will:

1. Declare that the parties to the contract are independent entities, each responsible for the acts and/or omission of the other.
2. Include standard provisions for licensure and certification, liability insurance coverage, maintenance of and access to records, credentialing and profiling information, provisions for termination and dispute resolution; and be it further

RESOLVED, that the "Standard Physicians Service Agreement" will not set fees, but refer to a blank fee schedule of CPT codes which will be negotiated by each individual physician.

### **Recommendations, Reference Committee 4:**

Reference Committee No. 4 reviewed Resolution L, Standard Physician's Service Agreement, introduced by the Jefferson County Medical Society, and heard eloquent testimony from Michael Macfarlane, MD, Louisville. Reference Committee No. 4 assumes the editorial prerogative of making the word, "omissions," a plural in the third "Resolved," and recommends that Resolution L be referred to the Board of Trustees for further discussion and consideration.

Mr Speaker, I recommend the adoption of the Report of Reference Committee No. 4 as a whole, as amended.

Mr Speaker, I want to personally thank the other members of Reference Committee No. 4 who have attempted to assist the House of Delegates in formulating policies on some very worthwhile issues. Members of the Committee were: David J. Bensema, MD, Lexington; Susan G. Bornstein, MD, Louisville; John S. Bruner, Lexington (MSS); W. Ford Threlkeld, MD, Frankfort; and John R. White, MD, Lexington. I would also like to thank Diane Maxey for her assistance in preparation of this report.

Respectfully submitted,  
REFERENCE COMMITTEE NO. 4  
Joseph G. Weigel, MD, Somerset, Chair  
David J. Bensema, MD, Lexington  
Susan G. Bornstein, MD, Louisville  
John S. Bruner, Lexington (MSS)  
W. Ford Threlkeld, MD, Frankfort  
John R. White, MD, Lexington

**Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.**

## **REPORT OF REFERENCE COMMITTEE NO. 5**

**Susan H. Prasher, MD, Ashland, Chair**

36. Report of the Committee on Maternal and Neonatal Health



37. Report of the Technical Advisory Committee on Physician Services (Medicaid)
38. Report of the Committee on Community and Rural Health
39. Report of the Committee on Physical Education and Medical Aspects of Sports
40. Report of the Committee on Child and School Health
41. Report of the Judicial Council
  - Resolution A — Privatization of Medicaid (Board of Trustees)
  - Resolution B — Medicaid Block Grant Funding (Board of Trustees)
  - Resolution C — Medicaid Managed Care (Board of Trustees)
  - Resolution S — Medicaid Reimbursement (Floyd County Medical Society)
  - Resolution V — Medicaid Funding (Charles E. Hardin, MD)

#### ITEMS FOR CONSENT

Reference Committee No. 5 reviewed the following items and recommends they be filed, by consent of the House, without discussion:

37. Report of the Technical Advisory Committee on Physician Services (Medicaid) — filed
38. Report of the Committee on Community and Rural Health — filed
41. Judicial Council — filed

Reference Committee No. 5 would like to express its appreciation to the chairs and members of the committees for their efforts in dealing with the issues discussed in the reports.

Mr Speaker, Reference Committee No. 5 recommends adoption of the Consent Calendar as a whole.

### Report of the Technical Advisory Committee on Physician Services (Medicaid)

The Technical Advisory Committee on Physician Services (Medicaid), "Physician TAC," is one of 11 provider groups represented on the Advisory Council for Medical Assistance. The Physician TAC meets as needed to discuss and evaluate problems and concerns faced by physicians when dealing with the Kentucky Medical Assistance Program (Medicaid). If the Physician TAC determines that the issues discussed require action, the Chair presents these issues in the form of a written report to the Advisory Council and makes a formal recommendation for action.

Pursuant to a formal opinion from the Cabinet for Human Resources (CHR) in 1991, all technical advisory committees continue to be subject to the provisions of Kentucky open meetings laws, KRS 61.805-61.850. These laws stipulate that meetings shall be open to the public and shall be scheduled to allow effective public observation and news media coverage.

During the past year, the Physician TAC and KMA nominated physicians to serve on the Drug Formulary Advisory Board (DFAB) and the Drug Use Review Advisory Board (DURAB). Both of these advisory boards are mandated by federal law to serve in an advisory capacity to the Medicaid program. Administrative orders were issued in December 1992 to formulate these advisory boards, and membership on each board includes four physicians selected from a list of nominees provided by KMA. The DFAB advises the Department for Medicaid Services on matters relating to the outpatient drug list, drug prior authorization process, coverage status for new drugs and other drug-related matters, and makes recommendations to the Medicaid Commissioner concerning the composition of outpatient drug lists.

Responsibilities of the DURAB include advising the Department for Medicaid Services on matters relating to drug use therapy, making recommendations to the Medicaid Commissioner on retrospective drug use review standards, developing educational topics on common drug therapy problems and improvement in quality of drug therapy, and establishing standards for identification of suspected fraud and abuse.

During the past year, the Physician TAC met formally on one occasion and informally via the telephone and correspondence on other occasions to review concerns expressed by Kentucky physicians about the Medicaid program. The major issue discussed during the course of the year concerned the Medicaid Managed Care Initiative proposed by CHR. In this proposal, Medicaid would be converted to a fully capitated plan that would be insti-

tuted in eight (8) separate regions of Kentucky.

Among other items discussed by the TAC was preauthorization of certain psychiatric medications. It was clarified by Department of Medicaid staff that psychiatric medications for a psychiatric diagnosis can be requested through the preauthorization program by any licensed physician if all preauthorization requirements are met. The patient is not required to see a psychiatrist before the physician can preauthorize the medication.

Also discussed by the TAC was the concept of patient confidentiality and Medicaid. It was noted that when a Medicaid participating physician signs a Participation Agreement, authorization is given to the Department of Medicaid to access and review medical records. Further, the patient signs an authorization for release of medical records when applying for benefits.

Other items discussed by the TAC during the year included:

- Medicaid disease-based therapeutic algorithms for selected diseases. The TAC determined that algorithms are appropriate to be utilized as an educational tool for physicians, but never should be a substitute for a physician's clinical judgment.
- A 1994 survey of Medicaid physicians was reviewed for informational purposes.

The Physician TAC will continue its efforts to provide a meaningful forum for Kentucky physicians to present their concerns, suggestions, and ideas in order to provide quality medical services to Kentucky's indigent population.

As Chair, I would like to thank my fellow committee members for the time and effort they expended during this past year. I would also like to thank the KMA staff and the Department of Medicaid staff for their assistance throughout the entire year.

**A. O'tayo Lalude, MD**  
Chair

### Report of the Community and Rural Health Committee

The Community and Rural Health Committee met on one occasion this year to discuss various health and safety issues.

The committee previously recognized the need for physicians to have available current information for presentations to the public and other medical professionals on "HIV/AIDS." As a result, the committee worked through the East Kentucky AIDS Education and Training Center to develop a slide set on "HIV/AIDS in Kentucky."

Physicians giving presentations on HIV/AIDS can borrow a set of slides from the KMA office. The information will be updated by the East Kentucky AIDS Education and Training Center on an ongoing basis to maintain current statistics.

The committee also reviewed information on the State Health Study. Reginald F. Finger, MD, provided background information and an update on the status of the State Health Study currently being addressed by the Department for Health Services (DHS). The State Health Study was conceived about four years ago as a health interview and examination study of a representative group of Kentuckians to find out how healthy Kentuckians actually are and to answer questions on health care access, immunization coverage, and maternal and child health variables in order to compare to similar national studies. Two components of the study were conducted — a telephone survey of 6,000 people and an in-person clinical examination of a subsample of 2,300 people in Kentucky.

Once an analysis of the final data is performed and the steering committee overseeing the project approves it, then a final copy of the study will be available in late summer.

In other DSH matters, Dr Finger reported that 110 practices enrolled in the Vaccines for Children Program in February, when the requirements were changed to federally eligible only. He pointed out that adequate funding is available for the addition of the chicken pox vaccine, MMR vaccine, and some options for local health departments to have Hepatitis B vaccines for adolescents. Dr Finger also noted that funding is available for a statewide immunization information system once it is approved by the Governor's office. Dr Finger will continue to update the committee as plans develop further.

Dr Finger noted that a proposed administrative regulation, which would allow a Medicaid Administration fee for the administration of vaccines, a factor that is very important to pediatricians, is now going through the Cabinet's clearance process. If passed, the regulation would allow doctors





to be reimbursed for administering vaccines. Dr Finger also noted that immunization rates are now over 70% due to the aforementioned efforts, and the goal for the year 2000 is for 90% of children to be vaccinated on schedule. Dr Finger reported that the Department for Health Services now has a simplified and "harmonized" vaccine schedule for the state of Kentucky.

The committee reviewed Resolution K — Smoke-Free Dining, which was adopted by the KMA House of Delegates at the KMA Annual Meeting in September 1994. After extensive discussion regarding implementation of the resolution, the committee contacted the Kentucky Restaurant Association by letter and included a copy of Resolution K, proposing to open dialogue about joint sponsorship of a voluntary effort for smoke-free dining in restaurants in Kentucky. The committee also suggested that the KMA encourage county medical societies to work with local restaurant associations on this voluntary effort. An article was placed in the *May Communicator* urging all county medical societies to work with local constituencies on Resolution K.

The committee also discussed the issue of disability insurance for medical students and residents. A student member of the committee noted that some students this year had attempted to arrange for disability insurance but failed for various reasons. Since medical students and residents may be subject to risks causing long-term consequences to their ability to practice medicine, the committee noted that it is crucial to get disability coverage. In many cases, students and residents have accumulated large loans to cover school expenses without sufficient insurance coverage to pay off loans in case of disability. It was noted that the American Medical Association has a policy on disability insurance for students and residents. The AMA urges "all medical schools to pay for or offer affordable policy options, and assuming the rates are appropriate, require enrollment in disability plans by all medical students; and all residency programs to pay for or offer affordable policy options for disability insurance, and strongly encourage the enrollment of all residents in such plans." As a result of the discussion, the committee sent the deans of the medical schools a letter inquiring about each university's policy on the issue. The committee will pursue this at a future meeting.

Baretta R. Casey, MD, Chair, Subcommittee on Domestic Violence, reported to the committee on the activities of the subcommittee. While the subcommittee did not meet formally this year, it has dealt with many issues informally through telephone calls, correspondence, and meetings of the Legislative Task Force on Domestic Violence, of which Dr Casey is a member. The subcommittee, when established, was charged with recommending to the Kentucky Medical Association methods to improve physician education in order to better deal with the complex problem of domestic/interpersonal violence. The subcommittee has met both short- and long-term goals it initially set including educating physicians on domestic violence; instructing physicians on the present laws in Kentucky as they relate to reporting known and suspected domestic violence; educating communities by providing brochures to physician offices, hospitals, and other public places; and recommending that medical schools in Kentucky implement courses on diagnosing abuse victims. The subcommittee is in the process of establishing new goals as it advises the Legislative Task Force on Domestic Violence on issues of concern to the medical community. Dr. Casey will be testifying on behalf of the subcommittee to the Task Force in late summer, and will continue to oversee recommendations of the Task Force to the Legislature.

The subcommittee will continue to educate physicians on the issues of domestic violence and will be looking at regional education opportunities.

A statewide seminar on domestic violence was scheduled this year, but it seems a more regional focus for physician education is needed to best suit the needs of physicians. The subcommittee encourages physicians who are interested to become involved in the work of the subcommittee.

On behalf of the Community and Rural Health Committee, I would like to thank the Board of Trustees for being permitted to serve.

**Edmond A. Hooker, MD  
Chair**

## Report of the Judicial Council

Your KMA Judicial Council has met formally on one occasion over the past year and has dealt with many other issues/concerns informally via telephone calls and correspondence.

A major portion of the council's activities during the past year were directed at patient complaints and acting as arbiter on many varied physician activities. Many patient complaints continue to relate to the release and/or transfer of patient records. While it was hoped that provisions in House Bill 250 (Kentucky's so-called health system reform legislation) and House Bill 928 (Workers' Compensation reform measure) would alleviate many patient complaints in this area, problems still exist. KMA's legal counsel has drafted a summary of the medical records provisions of House Bill 250 and House Bill 928 which has been circulated to all Kentucky physicians and published in the *KMA Journal*. The council recommends that this excellent resource be utilized by physicians when confronted with medical records questions.

Another area of ongoing concern for the council has been the issue of self-referral. The Kentucky Legislature also addressed this issue in House Bill 250 by adopting the federal Stark II provisions as law in Kentucky. These provisions became effective on January 1, 1995, and do not allow physicians to bill Medicare, Medicaid, or any individual or third-party payor for services furnished following a prohibited referral. This new state law has helped to address many of the questions in this area submitted by physicians. However, due to the federal government's failure to issue guidelines/regulations on Stark II, many questions remain unresolved.

Other cases referred to the Judicial Council over the past year included a complaint from a patient that his treating physician misdiagnosed his condition and was insensitive and rude during office visits. This complaint was thoroughly reviewed and the physician and patient amicably resolved their differences. Another case recently received concerns a complaint by a physician that his clinical hospital privileges were removed without adequate due process. The council continues to investigate this matter.

The council wishes to thank the KMA Board of Trustees for its support and cooperation. Many times over the course of the year, local trustees are called upon by the council to investigate matters in their trustee districts and report their findings back to the council. Without this cooperation, the council could not function effectively.

The council is honored to serve the Association and urges all KMA members to recognize their professional responsibilities and obligations and to adhere thereto.

**William P. VonderHaar, MD  
Chair**

## END OF CONSENT CALENDAR ITEMS

### Report of the Committee on Maternal and Neonatal Health

The Committee on Maternal and Neonatal Health convened on two occasions during the Association year. For two years the committee has explored ways by which greater emphasis can be given to teaching family life skills in our school systems. Teenage pregnancies and the growing menace of sexually transmitted diseases (STDs) pose tremendous budgetary concerns and potential health crises within our society.

Ms Terry Vance of the Department of Education, an ex-officio member, briefed the committee on the Kentucky Education Reform Act (KERA) and its impact on parenting and family life curriculum. She explained that the Parenting and Family Life Skills Act adopted by the 1988 Kentucky General Assembly required the teaching of parenting and family life skills to pupils in Kentucky schools. The Act required the Department of Education to develop a model curriculum that local school districts could use as a guide when designing curriculum to meet the specific needs of their own pupils. A Parenting and Family Life Skills Task Force worked to develop a model curriculum. Pat Nicol, MD, a former member of this committee, and Tom Young, MD, a member of KMA's Child and School Health Committee, were members of the Task Force. Vance noted that the 1988 curriculum was an excellent model program which included guidelines for teaching interpersonal skills, AIDS, and STDs, with information being provided to students progressively, allowing more advanced instruction as they mature.

Unfortunately, the enactment of KERA in 1990 eliminated all mandates and placed responsibility for curriculum on "Site-based Decision Making Councils" made up of the local school principal, two teachers, and two



parents. It was pointed out that several KMA committees have shown an interest in this program and its reinstatement. After extensive study and discussion, the Committee on Maternal and Neonatal Health recommended support for the "Parenting and Family Life Skills Education: A Model Curriculum" and encourages KMA to work toward reenactment of this program in the public schools.

Due to the fact that the KMA Board of Trustees designated the formation of a new Committee on Child and School Health, the committee's recommendation was forwarded directly to the new committee for consideration and further exploration.

Mr Mike Townsend of the Cabinet for Human Resources, Division of Substance Abuse, addressed the committee regarding the problem of women and substance abuse, particularly during pregnancy. He explained the background of a Task Force which initiated legislation passed in 1992 to address this problem. Committee Chair Cooper currently serves as a member of the work group appointed to study this issue. Mr Townsend provided statistics on women and substance abuse and suggested ways for KMA to assist in alleviating this problem.

As a result of Mr Townsend's presentation the committee contacted the two medical schools in an attempt to determine "the cost of not treating substance abuse in pregnant women." Stanley A. Gall, MD, Professor and Chairman of the UL Department of Obstetrics and Gynecology, noted that obtaining existing data on medical costs for treatment of substance abuse during pregnancy is a complicated issue. Dr Gall went on to note, "the issue is complicated because the largest number of pregnant patients with substance abuse receive little prenatal care. In addition, the rate of prematurity is very large and these infants end up in the intensive care units for prolonged periods of time. At the current time we have no mechanism or resources for calculating the cost of failure for non-treatment of substance abuse problems. We would be very happy to work with you and KMA in developing funding sources to study this important problem."

Kenneth E. Holtzapple, MD, Professor and Chairman of the UL Department of Family and Community Medicine, reported that the department had no information on patient population relating to medical costs for treatment of substance abuse during pregnancy or about cost of failure for non-treatment of substance abuse problems. However, Dr Holtzapple did point out that faculty member Steve Wheeler, MD, did write a literature review about substance abuse during pregnancy which was published in *Primary Care* in 1993. In the article, Dr Wheeler notes:

Substance abuse during pregnancy is a problem of enormous scope and staggering social and medical implications.

Using data from the 1990 National Institute on Drug Abuse (NIDA) Household Survey on Drug Abuse, Khalsa and Groerer estimated that of the approximately 60 million women of childbearing age (15 to 44 years), 50.8% used alcohol, 29% smoked cigarettes, 6.5% used marijuana, 0.9% used cocaine, and 8.0% used any illicit drug during the past month. These figures represent a decline in past month alcohol, cigarette, marijuana, and cocaine use when compared with a similar survey in 1985, which showed that 60.9% used alcohol, 33.4% smoked cigarettes, 11.2% used marijuana, 3.5% used cocaine, and 14.8% used any illicit drug within the past month.

Similar trends were found among college seniors at a single institution anonymously surveyed in 1969, 1978, and 1989. Most forms of illicit drug use, which had become more prevalent between 1969 and 1978, declined substantially in the 1989 study. This decline was not true of alcohol use, which remained stable at 97% having ever used and approximately 40% using it at least weekly.

Translating these figures to drug use during pregnancy is problematic, and similar estimates generalizable to the nation are not yet available. NIDA is currently funding a national hospital-based survey that should provide data within the next year on the prevalence of licit and illicit drug use during pregnancy and limited data on infant outcomes. In the meantime, selected currently available studies speak to the scope of the problem. Using data such as these, the National Association for Perinatal Addiction Research and Education estimates that as many as 375,000 infants are born in this country to mothers who abuse illicit drugs. This figure does not include exposure to alcohol and nicotine. Opiates include such drugs as heroin, opium, morphine, and codeine. It is estimated that 150,000 to 200,000 women in the United States are addicted to opiates (principally heroin) and that they give birth to at least 5,000 infants each year.

Copies of this extensive study and outstanding report may be obtained by contacting the University of Louisville. We congratulate and thank Dr Wheeler for his work in this area.

All responses received from the medical schools in answer to the committee's survey regarding the cost of "failure to treat" addicted pregnant women were reviewed. The committee also reviewed the Department of Substance Abuse's suggested ways that KMA could help in the area of women and substance abuse and noted committee responses on each item:

1. Support for reenactment of the Family Life Skills curriculum in schools. — **YES**
2. Screening and referral by physicians in the private and public sector for patients with substance abuse problems. — **The committee will adhere to recommendations of KMA's 1990 Ad Hoc Committee on Maternal/Fetal Conflict.**
3. The need for physicians' training. — **YES — Are physicians in training receiving enough training in this area? This would involve some extra training for physicians during their training years. Recommend re-education.**
4. When utilizing a managed care approach, could we develop a common point of entry for referrals for substance abuse assessments and referral to treatment? — **Find systematic referral for these patients and work at this later.**
5. Need for a media campaign on "Shame and Stigma" associated with female chemical dependency. Would KMA support this? — **Committee first needs a definition of "support," but feels this is an issue that needs to be addressed.**
6. Need to assess "Cost of Failure" for not treating substance abuse problems. Can the KMA assist in determining costs associated with untreated substance abuse in terms of infant and pediatric care and medical problems of the mother? — **YES — The committee will continue to be aware of this and will continue to work with the Task Force to obtain this information.**
7. Would KMA support a warning sign on the use of tobacco during pregnancy? — **YES — The committee recommends that physicians place signs in their offices warning of the dangers of smoking while pregnant.**

The committee will continue to work with CHR and the Department of Substance Abuse in the coming year.

The committee reviewed the following AMA reports and resolutions relating to maternal and neonatal health:

- Board of Trustees Report 24-1-94 addressed the issue of the impact of 24-hour postpartum stay on infant and maternal health. In this report the Board requests the Council on Scientific Affairs to study the issue of 24-hour postpartum discharge of mothers and infants, to evaluate the impact of this practice on infant and maternal health, and to report back to the House of Delegates at the 1995 Annual Meeting.
- AMA Resolution 107 (1-94) was adopted as AMA policy and "strongly advocates that all public and private payers provide financial support for the rental and/or purchase of breast pumps."
- AMA Resolution 303 (1-94) was also adopted as AMA policy and stated "Resolved that the AMA adopt as policy that alcohol and other drug abuse education needs to be an integral part of medical education; and be it further Resolved, that the AMA support the development of programs to train medical students in the identification, treatment, and prevention of alcoholism and other chemical dependencies."

The Lexington-Fayette County Health Department requested the support of KMA (through this committee) in proposing that the Health Policy Board include insurance coverage for lactation services in the maternal and child health provisions of the standard benefits plan currently being developed. Since KMA policy opposes mandated insurance benefits, the health department has been informed that although the committee is supportive of the concept of breastfeeding, it is not empowered to endorse the proposal.

The Spina Bifida Association and its "Project Healthy Babies" is focusing on the importance of folic acid during pregnancy. The association requested that an article be placed in the *Communicator* encouraging physicians to stress the importance of folic acid in their expectant mothers. An article was subsequently placed in the *Communicator* regarding the importance of folic acid in the prevention of spina bifida.

The following referrals were forwarded to the Committee on Maternal





and Neonatal Health by the 1994 House of Delegates:

1. The recommendation of the 1993-94 Committee on Maternal and Child Health that KMA adopt the guidelines for hospital discharge of mother and newborn established by the Wisconsin Association for Perinatal Care. **A copy of these guidelines was mailed to all hospital administrators and presidents of the following specialty groups: (1) OB/GYN, (2) Pediatrics, and (3) Family Practice. In addition, the guidelines were included in the December 1994 Communicator.**
2. Resolution N — Primary Care During Perinatal Period Resolution N declared that "obstetricians be regarded as primary care physicians to their obstetrical patients during the perinatal period."

**This resolution was accepted as an informational item.**

On behalf of the members of the committee we appreciate the opportunity to be of service to our patients and profession and look forward to 1995-96. Special thanks to Ms Terry Vance, a staff member of the Department of Education, who has been of invaluable service as an ex-officio member to the committee and its work. We are also appreciative of Mr Mike Townsend, Director of CHR's Substance Abuse Division, and members of his staff for their support during the year. We have enlisted the services of Ms Lynn Flynn, from the Department of Maternal and Child Health, and appreciated Ms Flynn's contributions.

**J. Gregory Cooper, MD**  
Chair

## Report of the Committee on Child and School Health

The newly formed Committee on Child and School Health held its organizational meeting on November 16, 1994. Following a survey of committee members, the following topics were suggested for study:

1. School Health Linked Clinics
2. Kentucky Early Intervention System
3. Evaluation and Coordination of Services in Children with Learning Disorders
4. Attention Deficit Hyperactive Disorder
5. Administration of Medication in Schools
6. Vaccine in Schools

The committee was updated on KMA's lawsuit challenging the Cabinet for Human Resources' Medicaid reimbursement cuts. The committee expressed concern for the reduction, particularly its effect on maternal and pediatric care and access to health care for the indigent.

Since Kentucky is one of only a few states without a mandated health education curriculum in the public school system, the committee expressed optimism that family life education be addressed by the General Assembly. It was suggested that a subcommittee be considered to discuss the topic of mandatory health education in schools. Ms Terry Vance, ex-officio member representing the Department of Education, gave the committee a full report on past activities of the General Assembly relating to mandating health education in public schools.

J. Gregory Cooper, MD, Chair of KMA's Maternal and Neonatal Health Committee, spoke to the Child and School Health Committee regarding his committee's concerns for the lack of family life skills curriculum in public schools. He discussed the history of Kentucky's curriculum, how it was nullified by the enactment of KERA, and urged the two committees to work together to reinstate health education, including family life skills, into Kentucky's schools, grades K-12. The Committee on Child and School Health recommends the following:

The Child and School Health Committee reaffirms the KMA House of Delegates position that health education be taught to all students from kindergarten through the 12th grade. The committee recommends the development of a comprehensive school health education plan of which parenting and family life skills is a facet. The committee further recommends to the KMA Board of Trustees that an ad hoc committee be formed from individuals in the private sector, government (including legislative and administrative), and physicians (including members of the KMA Child and School Health Committee and KMA Maternal and Neonatal Health Committee) to study school health education and to present recommendations to the KMA House of Delegates.

The committee's recommendation was forwarded to the July meeting

of the KMA Executive Committee and the August meeting of the KMA Board for Trustees for consideration. The House of Delegates will be informed if there is any obstacle or objection to the appointment of an ad hoc committee to consider the committee's recommendation.

The issue of initial entry and 6th grade physical examinations was referred to the Kentucky Board of Medical Licensure (KBML) for an opinion on who can perform school physician examinations. The Board responded that nonphysician practitioners must be under the supervision of a physician to perform these exams. According to Terry Vance of the Department of Education, nonphysician practitioners have been cautioned by the Department to follow proper protocol of their profession. Lynn Flynn of CHR explained to the committee that although it is not an ideal situation, some children in rural Kentucky must receive their exams from one of the aforementioned practitioners or not receive medical care at all. The committee urges that communication between pediatricians and health department workers be increased.

On behalf of the members of the committee including Mary C. Guiglia, MD; James Harring, MD; Donald R. Neel, MD; Kathy Nieder, MD; William Watkins, MD; Thomas L. Young, MD; William D. Hacker, MD; and ex-officio members Ms Terry Vance and Ms Lynn Flynn, we appreciate the challenge that has been presented to us. We expect to be even more active in the coming year and appreciate the confidence the Board of Trustees has entrusted to us.

**Thomas H. Pinkstaff, MD**  
Chair

## Recommendations, Reference Committee 5:

Reference Committee No. 5 reviewed Report No. 36 — Report of the Committee on Maternal and Neonatal Health and Report No. 40 — Report of the Committee on Child and School Health.

The Reference Committee recommends that KMA affirms support for "Parenting and Family Life Skills Education" curriculum in public schools mentioned in both reports.

The Reference Committee recommends that Reports 36 and 40 be adopted.

## Report of the Committee on Physical Education and Medical Aspects of Sports

The KMA Committee structure was reviewed by the Board of Trustees and several committee responsibilities were reassigned. With its new responsibilities in mind, the Committee on Physical Education and Medical Aspects of Sports adopted the following Mission Statement:

**The Committee on Physical Education and Medical Aspects of Sports is concerned with matters relating to the improvement of the overall health of the school-age child. It recommends programs to the KMA Board of Trustees and advises the State Board for Elementary and Secondary Education, the Kentucky High School Athletic Association, other interested agencies, and the physicians of Kentucky, through the Board, of programs that would result in the development of stronger bodies, both mentally and physically, and in preventative programs that would eliminate and/or correct matters that might be detrimental to the health of our youth at an early stage.**

One of the major ongoing projects and responsibilities is to conduct Sports Medicine Symposia for the Kentucky High School Athletic Association. The State Board for Elementary and Secondary Education regulations require that KHSAA assure that every athletic coach in high school sports attends a symposium biennially and achieves their continuing education.

The committee conducted 1994 Sports Medicine Symposia in the following locations:

Meadowview Regional Hospital, Maysville  
Ephraim McDowell Regional Medical Center, Danville  
Male High School, Louisville  
Jewish Hospital, Shelbyville  
Murray-Calloway County Hospital, Murray  
Trover Clinic, Madisonville  
King's Daughters' Medical Center, Ashland



Union College, Barbourville  
 Hyatt Regency, Lexington  
 KAPO, Richmond  
 Northern Kentucky University, Highland Heights  
 Makeup Symposium — Richmond  
 Makeup Symposium — Elizabethtown

The committee amended the *Guidelines for Sports Medicine Symposia*, established by this committee in 1990, to permit six hours of instruction and one hour for lunch at each symposium, beginning in 1995 (constituting a 7-hour day), and to include the topic of "Psychological Aspects of Sports" in the endorsed subjects.

The following schedule has been approved for 1995 Sports Medicine Symposia. The physician sponsor of each program appears in parentheses:

1. April 22, 1995 — Meadowview Regional Hospital, Maysville (Mike Miller, MD)
2. April 22, 1995 — Barren County High School, Glasgow (Barret Lessenberry, MD)
3. April 29, 1995 — Ephraim McDowell Medical Center, Danville (Quin Bailey, MD)
4. May 11, 1995 — BioKinetics, Paducah (William J. Stodghill, MD)
5. June 3, 1995 — University of Louisville (R. Shea, MD & R. John Ellis, MD)
6. June 9, 1995 — Trover Clinic, Madisonville (J. Bowles, MD & J. Roe, MD)
7. June 10, 1995 — Jewish Hospital, Shelbyville (Ron Walldridge, MD)
8. June 17, 1995 — King's Daughters' Medical Ctr, Ashland (Garner Robinson, MD)
9. June 17, 1995 — Jenny Wiley State Park, Prestonsburg (David Caborn, MD)
10. June 24, 1995 — Eastern KY University, Richmond (Mary Ireland, MD)
11. June 24, 1995 — Kentucky Clinic, Lexington (David Caborn, MD)
12. July 8, 1995 — Union College, Barbourville (Ben Kibler, MD)
13. July 14, 1995 — Western KY University, Bowling Green (Craig Beard, MD)
14. July 22, 1995 — Northern KY University, Highland Heights (Mike Miller, MD)
15. October 7, 1995 — Eastern KY University, Richmond (Mary Ireland, MD)
16. October 7, 1995 — Brown Hotel, Louisville (Ron Walldridge, MD)

The use of exhibits at symposia as a means of defraying cost was discussed and it was stressed that each chairperson should be aware that these symposia are not to be viewed as profitmaking programs by hospitals or institutions. KHSAA will approve more stringent rules for enforcing the requirement that high school coaches attend a sports medicine symposium every other year.

Committee members James M. Bowles, MD, and Joseph E. Roe, MD, addressed the committee regarding proposals to offer an Athletic Trainer Emergency Care education program in Western Kentucky and the need for the committee's endorsement. This program bridges the gap between athletic trainers and emergency medical technicians as it relates to athletic injuries. The 16-hour course is given by a medical doctor, emergency medical technician, and certified athletic trainer and costs approximately \$25. The committee adopted a motion recommending the implementation of the Athletic Training Emergency Care course in the state of Kentucky.

Mr Julian Tackett, KHSAA representative to the committee, addressed several issues of interest to the committee:

- (1) KHSAA has been requested to require steroid testing in all high school athletes but cannot comply at this time and thought this committee might be interested. After discussion, it was determined that this is not feasible.
- (2) A new rule in football which allows a player to participate while wearing a cast (with physician approval) requires a medical form be developed by KHSAA. The form will be submitted by KHSAA to this committee for review.
- (3) Issues suggested by various groups to the KHSAA for further consideration include requiring an ambulance and athletic trainer be present at every high school football game in the state, soccer safety, and physician coverage at athletic events.

Mr Tackett reported that KHSAA would attempt to have an age restriction added to HB 750 which was adopted in 1992 with KMA's assistance.

The bill now restricts participation in several high school sports to students who have successfully completed the 8th grade. This committee will be asked to review the proposed amendment at its October meeting.

The Kentucky Nursing Association and others continue efforts to amend KHSAA Bylaw 28 to allow nurse practitioners and other health care providers to perform the required annual physical examination for athletes. The bylaw now states that a physician must certify the athlete's physical ability to participate in sports. A letter from KMA President Robert R. Goodin, MD, and Committee Chair R. Quin Bailey, MD, opposing this change was sent to Commissioner of Education Thomas C. Boysen, and KHSAA Commissioner Louis Strout. According to Mr Tackett this letter was forwarded to all KHSAA Board members.

The committee has grave concerns with this proposal. In a highly charged emotional athletic contest, with tremendous physical contact required in many interscholastic sports, the physical examination of an athlete by a physician is crucial. Physicians have diagnosed serious ailments in virtually hundreds of athletes that prohibited or delayed their participation in sports. The physical examination of an athlete should never be taken lightly nor should the responsibility be given to anyone other than a physician.

We believe that any reduction in the quality of care which these athletes receive and deserve will raise serious concerns among team physicians who may be highly reluctant to serve in that capacity if the physical exam has not been rendered by a physician. The KMA has a long history of support for the sports programs of Kentucky high schools, the KHSAA, and the Kentucky Board of Education. We fear that individual support by physicians could be eroded by the adoption of this unnecessary and inappropriate proposal. We believe this proposal poses danger to the athlete and markedly affects quality of medical care and potential standards of participation required for high school athletics.

After due consideration the KHSAA rejected the ARNP proposal. However, KNA has returned once again and asked for reconsideration. We have responded again to their proposal.

Following the catastrophic injury suffered by a Northern Kentucky physician's son in November 1994, the physician attended a committee meeting and made several recommendations for the committee's consideration to ensure safety of student football players:

1. Play should end when the football breaks the front plane of the end zone.
2. The present rule of illegal head hitting and spearing should be strictly enforced to avoid serious injuries.
3. A committee should be established to review the rules and arrive at changes to prevent injuries and protect athletes.
4. A committee should be established to investigate major injuries. The committee should take into consideration not only the medical injuries but also the situation and events causing the injury.
5. The KHSAA should share the findings of their investigation with the parents, the coaches, and the school. At this time, the association should inform parents of KHSAA's responsibility for the medical and future financial obligations to the player.
6. The State Board of Education and KHSAA should require that a trainer and physician be present at every high school athletic event to give immediate life-saving attention.

A subcommittee was appointed to consider the recommendations and report back to the committee in the 1995-96 Association year. The subcommittee will also investigate equipment rules, player size adjustments, spear tackling, and penalties presently imposed.

The committee is deeply appreciative of the support KHSAA and the Department of Education provides to the committee. We are especially privileged by the attendance and participation of Ms Terry Vance of the Department of Education and Mr Julian Tackett, staff member of KHSAA. We are impressed with their concern for children and the student athlete. Without the Department of Education and KHSAA, along with the participation and interest of these fine public servants, the effectiveness of this committee would be greatly diminished.

On behalf of the members of the committee we have enjoyed our participation in this endeavor and appreciate the confidence the public and the profession has in our efforts to serve and protect the student athlete.

**R. Quin Bailey, MD**  
 Chair





#### **Recommendations, Reference Committee 5:**

Reference Committee No. 5 reviewed the Report of the Committee on Physical Education and Medical Aspects of Sports. The Reference Committee agrees that all physical examinations for participation in school-sponsored sports should be done under the supervision of a physician. The Reference Committee would like to thank the chair and committee members for their work during this Associational year.

Reference Committee No. 5 recommends that Report No. 39 be filed.

### **RESOLUTION A**

#### **Privatization of Medicaid**

##### **KMA Board of Trustees**

WHEREAS, the candidates in Kentucky's 1995 Gubernatorial election and others have espoused the benefits of "privatizing" Kentucky's Medicaid program; and

WHEREAS, no specifics have yet been proposed which detail physician and patient rights under such a privatization plan or how such a plan would be implemented; and

WHEREAS, a waiver from the federal Health Care Financing Administration (HCFA) is necessary to implement such changes in Kentucky's Medicaid program; and

WHEREAS, any waiver would require assurances from the state that such plans are sufficient to enlist enough providers so that care and services are available to Medicaid recipients at least to the extent that such care and services are available to the general population; and

WHEREAS, no waiver requests have been filed with HCFA; now, therefore, be it

RESOLVED, that the KMA carefully monitor future state administration efforts to develop and implement any revision of the current Medicaid program; and be it further

RESOLVED, that to the extent possible, KMA offer the assistance of the Association and participate in any discussion of substantial changes to the current Kentucky Medicaid program as may be proposed by a future state administration; and be it further

RESOLVED, that any substantial revision of the Medicaid program structure must retain assurances that the plan be able to enlist enough physicians so that care and services are available to Medicaid recipients at least to the extent that such care and services are available to the general population; and be it further

RESOLVED, that if proposed revisions are not deemed to be in the best interest of the patient and physician, that appropriate legal, judicial, legislative or administrative actions to deal with such deficiencies be taken in the most expeditious manner.

#### **Recommendations, Reference Committee 5:**

Reference Committee No. 5 reviewed Resolution A, Privatization of Medicaid, introduced by the Board of Trustees. The Reference Committee recommends that Resolution A be adopted.

### **RESOLUTION B**

#### **Medicaid Block Grant Funding**

##### **KMA Board of Trustees**

WHEREAS, current Congressional leadership has indicated its intention to fund future Medicaid appropriations through a "block grant" mechanism; and

WHEREAS, details of the implementation of such grants are few; and

WHEREAS, Kentucky's Medicaid program has been growing in all categories by virtue of federally mandated expansions, Kentucky's economic situation and the general aging of the population; and

WHEREAS, it has been indicated that block grants would limit federal Medicaid funding to a set amount and would allow small incremental increases in that amount in the future; and

WHEREAS, funding the program through block grants, as proposed by Congressional leaders would likely have a significant and irreversible impact on Kentucky's Medicaid program; now, therefore, be it

RESOLVED, that the KMA Board of Trustees closely monitor the development and implementation of block grant Medicaid funding and take all reasonable, appropriate and necessary action to assure that such funds are used solely for the provision of appropriate medical services to eligible Medicaid recipients.

#### **Recommendations, Reference Committee 5:**

Reference Committee No. 5 reviewed Resolution B, Medicaid Block Grant Funding, introduced by the Board of Trustees. The Reference Committee recommends that Resolution B be adopted.

### **RESOLUTION C**

#### **Medicaid Managed Care**

##### **KMA Board of Trustees**

WHEREAS, increased costs in the Kentucky Medical Assistance Program have generated much discussion about development of a managed care mechanism to reduce these costs; and

WHEREAS, these discussions have defined managed care as an HMO-type or capitation plan; and

WHEREAS, KMA has endorsed and supported KenPac, the current Medicaid managed care program, which has saved some \$170 million between 1986 and 1991 and \$125 million per year since 1992, according to the Cabinet for Human Resources; and

WHEREAS, KenPac, a fee-for-service, assigned-gatekeeper plan, has served as a national model for Medicaid managed care and has been emulated by several other states because of its effectiveness; now, therefore, be it

RESOLVED, that KMA reaffirm its support for the KenPac program; and be it further

RESOLVED, that KMA closely monitor and, if appropriate, oppose by reasonable lawful means, any Medicaid managed care program proposed to supplant KenPac unless improvement over KenPac would result.

#### **Recommendations, Reference Committee 5:**

Reference Committee No. 5 reviewed Resolution C, Medicaid Managed Care, introduced by the Board of Trustees, and heard extensive comments of concern about the specific coverage policies by KenPac for Emergency Room visits for which no definitive answers were available.

The Reference Committee recommends that KMA obtain clarifying information from the Department of Medicaid Services and make formal communication with all physicians, Emergency Rooms and Hospitals.

The Reference Committee recommends Resolution C be adopted.

### **RESOLUTION S**

#### **Medicaid Reimbursement**

##### **Floyd County Medical Society**

WHEREAS, Medicaid reimbursement to physician providers has been traditionally low relative to reimbursement by other third-party payors; and

WHEREAS, many Kentucky physicians refuse to accept Medicaid patients because of the low reimbursement rate; and

WHEREAS, the present Kentucky State Administration has drastically decreased the reimbursement rate for Medicaid providers; and

WHEREAS, there is a threat of further decline in reimbursement rates for care of Medicaid patients if the 2% provider tax is repeated; now, therefore, be it

RESOLVED, that the KMA actively promote a reasonable reimbursement rate for Medicaid providers.

### **RESOLUTION V**

#### **Medicaid Funding**

##### **Charles E. Hardin, MD**

WHEREAS, Medicaid reimbursement rates are traditionally less than usual and customary rates; and

WHEREAS, the current reimbursement rates are prohibitively lower than usual and customary; and

WHEREAS, fewer and fewer physicians are willing to accept the lower reimbursement rates for care of Medicaid patients or practice in areas of high indigence; now, therefore, be it

RESOLVED, that the KMA strives for usual and customary reimbursement for Medicaid patients; and be it further

RESOLVED, that the KMA stands for adequate state general funding for the Medicaid program.





# 1995-96 KMA Committees

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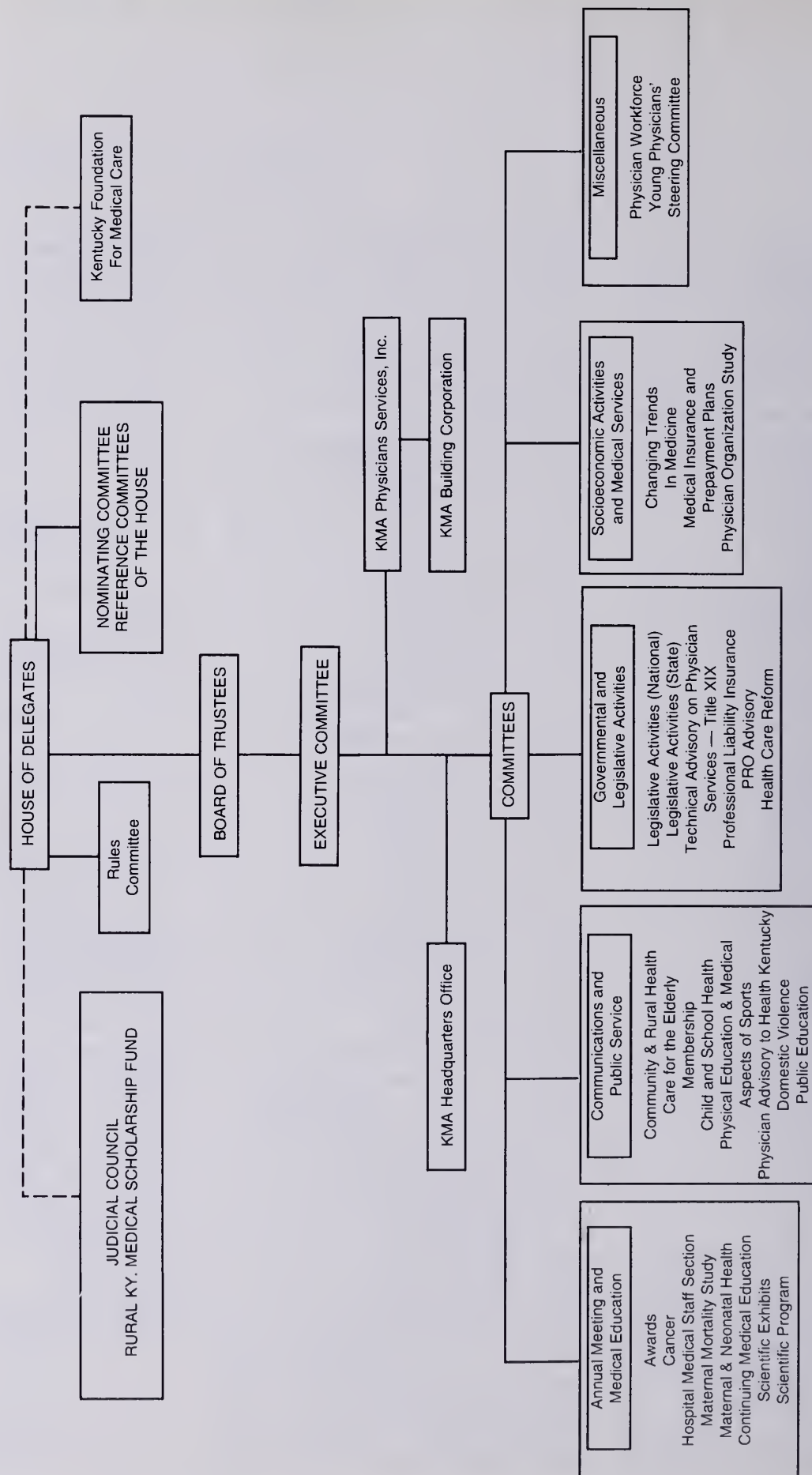
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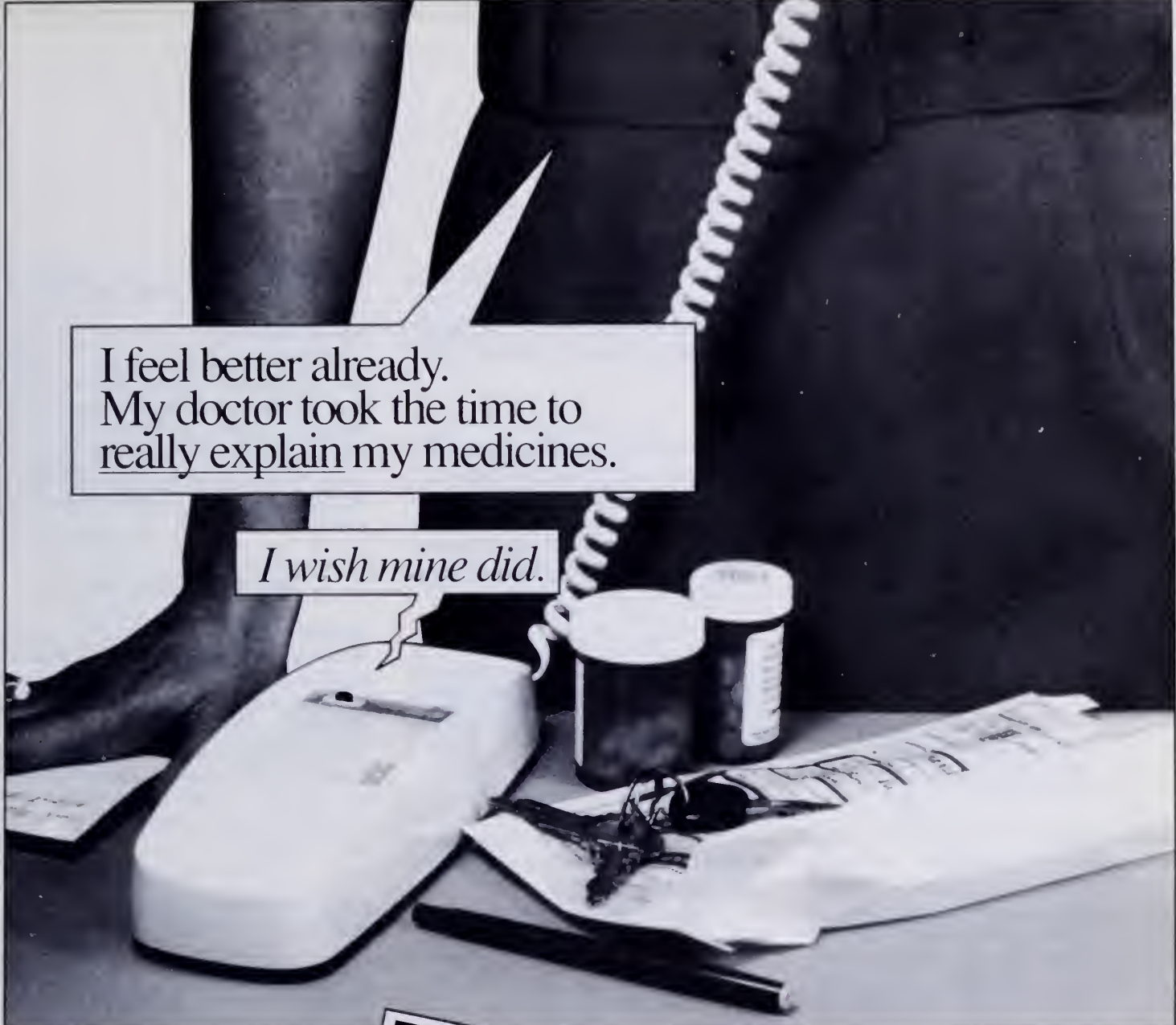
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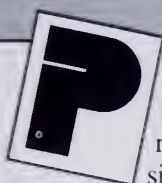
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The KMA Board of Trustees, in a cost containment effort, has discontinued publishing the Constitution & Bylaws of the Kentucky Medical Association in the *Journal*, unless there are significant changes in content. Copies of the Constitution & Bylaws of KMA may be obtained by contacting the headquarters office at 301 N Hurstbourne Pky, Suite 200, Louisville, KY 40222-8512.



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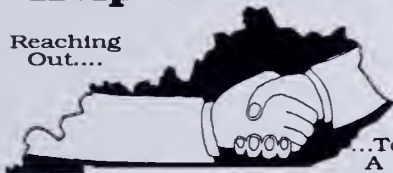
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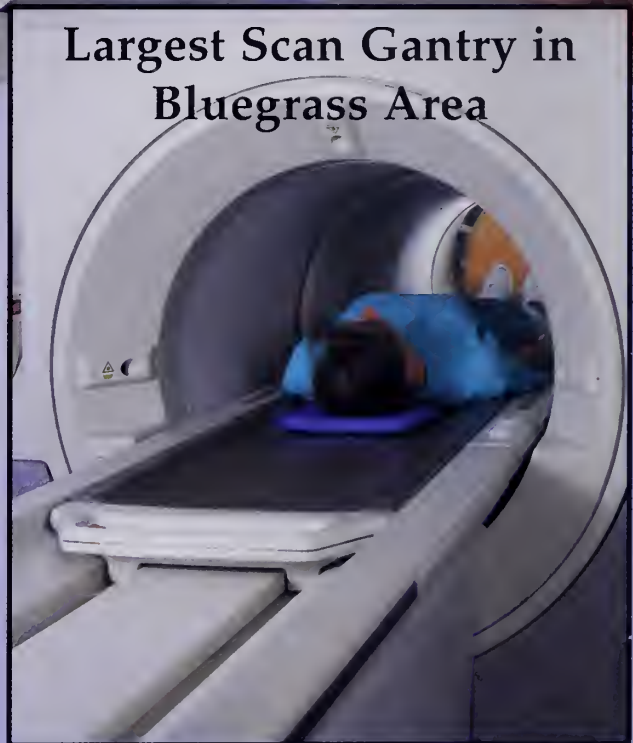
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